

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: 14-0115	Period: From 07/01/2018 To 06/30/2019	Worksheet S Parts I-III Date/Time Prepared: 11/29/2019 2:06 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 11/29/2019	Time: 2:06 pm
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (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 THOREK MEMORIAL HOSPITAL (14-0115) 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) _____

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	359,565	-22,083	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	359,565	-22,083	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: 14-0115		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/29/2019 2:06 pm		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 850 WEST IRVING PARK ROAD			PO Box:				1.00		
2.00	City: CHICAGO			State: IL		Zip Code: 60613		County: COOK 2.00		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	
								XIX		
Hospital and Hospital-Based Component Identification:										
3.00	Hospital			THOREK MEMORIAL HOSPITAL	140115	16974	1	07/01/1966	N P O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
17.20	Hospital-Based (OPT) I									17.20
17.30	Hospital-Based (OOT) I									17.30
17.40	Hospital-Based (OSP) I									17.40
18.00	Renal Dialysis									18.00
19.00	Other									19.00
							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)						2		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.					Y	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					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.					1	N		23.00	

Worksheet S-2
Part I
Date/Time Prepared:
11/29/2019 2:06 pm

MCRIF32 - 15.9.167.1

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0115		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/29/2019 2:06 pm	
			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
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part I
Date/Time Prepared:
11/29/2019 2:06 pm

	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0115	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part I Date/Time Prepared: 11/29/2019 2:06 pm	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	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.				109.00
			1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N		110.00	

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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.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1,665,088	3,690,041	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N			140.00

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1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	Contractor's Name:		Contractor's Number:				141.00	
142.00	Street:	PO Box:						142.00	
143.00	City:	State:		Zip Code:				143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			Y		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.			N				146.00	
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N		N		N		N	
156.00	Subprovider - IPF	N		N		N		N	
157.00	Subprovider - IRF	N		N		N		N	
158.00	SUBPROVIDER								
159.00	SNF	N		N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N		N	
161.00	CMHC			N		N		N	
161.10	CORF			N		N		N	
161.20	OUTPATIENT PHYSICAL THERAPY			N		N		N	
161.30	OUTPATIENT OCCUPATIONAL THERAPY			N		N		N	
161.40	OUTPATIENT SPEECH PATHOLOGY			N		N		N	
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					10/01/2012	09/30/2013		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			171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0115	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 11/29/2019 2:06 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	12/31/2019
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		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	11/07/2019	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: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part II
Date/Time Prepared:
11/29/2019 2:06 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				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.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				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.				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				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				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.				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.				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.				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.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				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.				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.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				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.	HATHUY		NGUYEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	STRATEGIC REIMBURSEMENT GROUP LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	630-530-7100 EXT 115		HATHUY.NGUYEN@SRGROUPLLC.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part II
Date/Time Prepared:
11/29/2019 2:06 pm

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER	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: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/29/2019 2:06 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	146	53,290	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)		146	53,290	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	10	3,650	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		156	56,940	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
25.10 CMHC - CORF	99.10				0	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.40
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)		156				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: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/29/2019 2:06 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6,334	1,785	22,086			1.00
2.00	HMO and other (see instructions)	1,866	9,927				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)	6,334	1,785	22,086			7.00
8.00	INTENSIVE CARE UNIT	112	0	161			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)	6,446	1,785	22,247	0.00	292.50	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)			81			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00	25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00	25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00	25.40
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	292.50	27.00
28.00	Observation Bed Days		0	717			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: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/29/2019 2:06 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,211	380	4,526	1.00
2.00 HMO and other (see instructions)			338	2,146		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,211	380	4,526	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
25.10 CMHC - CORF	0.00					25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0.00					25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00					25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00					25.40
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: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part II
Date/Time Prepared:
11/29/2019 2:06 pm

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	22,621,187	0	22,621,187	708,689.50	31.92
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		198,872	0	198,872	1,375.00	144.63
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		2,403,423	0	2,403,423	42,021.00	57.20
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		1,917,410	0	1,917,410	42,960.00	44.63
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		252,419	0	252,419	4,729.00	53.38
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		128,966	0	128,966	1,121.90	114.95
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		2,998,906	0	2,998,906		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		207,017	0	207,017		
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		6,626	0	6,626		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		202,493	0	202,493		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	90,039	0	90,039	2,126.00	42.35
27.00	Administrative & General	5.00	4,505,648	0	4,505,648	110,493.92	40.78

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part II
Date/Time Prepared:
11/29/2019 2:06 pm

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)	482,787	0	482,787	2,151.00	224.45	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	515,678	0	515,678	15,765.42	32.71	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)	635,839	0	635,839	35,267.00	18.03	33.00
34.00	Dietary	578,678	-120,698	457,980	34,238.00	13.38	34.00
35.00	Dietary under contract (see instructions)	268,527	0	268,527	4,160.00	64.55	35.00
36.00	Cafeteria	0	120,698	120,698	9,023.00	13.38	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	371,036	0	371,036	9,341.50	39.72	38.00
39.00	Central Services and Supply	93,410	0	93,410	6,019.00	15.52	39.00
40.00	Pharmacy	712,134	0	712,134	15,577.46	45.72	40.00
41.00	Medical Records & Medical Records Library	481,467	0	481,467	20,667.48	23.30	41.00
42.00	Social Service	317,851	0	317,851	3,655.05	86.96	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part III
Date/Time Prepared:
11/29/2019 2:06 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	21,604,917	0	21,604,917	708,246.50	30.50	1.00
2.00	Excluded area salaries (see instructions)	1,917,410	0	1,917,410	42,960.00	44.63	2.00
3.00	Subtotal salaries (line 1 minus line 2)	19,687,507	0	19,687,507	665,286.50	29.59	3.00
4.00	Subtotal other wages & related costs (see inst.)	381,385	0	381,385	5,850.90	65.18	4.00
5.00	Subtotal wage-related costs (see inst.)	3,005,532	0	3,005,532	0.00	15.27	5.00
6.00	Total (sum of lines 3 thru 5)	23,074,424	0	23,074,424	671,137.40	34.38	6.00
7.00	Total overhead cost (see instructions)	9,053,094	0	9,053,094	268,484.83	33.72	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0115	Period: From 07/01/2018 To 06/30/2019	Worksheet S-3 Part IV Date/Time Prepared: 11/29/2019 2:06 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		20,881	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		0	8.02
8.03	Health Insurance (Purchased)		1,526,204	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		47,449	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		11,750	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		1,469	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		82,265	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		137,080	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		1,565,616	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		17,328	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		5,000	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		3,415,042	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COST		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part V
Date/Time Prepared:
11/29/2019 2:06 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	635,690	2,587,125	1.00
2.00	Hospital	635,690	2,587,125	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
16.10	Hospital-Based-CMHC 10	0	0	16.10
16.20	Hospital-Based-CMHC 20	0	0	16.20
16.30	Hospital-Based-CMHC 30	0	0	16.30
16.40	Hospital-Based-CMHC 40	0	0	16.40
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0115

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

Worksheet S-7

Date/Time Prepared:
11/29/2019 2:06 pm

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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0115

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

Worksheet S-7

Date/Time Prepared:
11/29/2019 2:06 pm

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0115	Period: From 07/01/2018 To 06/30/2019	Worksheet S-10 Date/Time Prepared: 11/29/2019 2:06 pm
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.320864 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	12,061,278		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y		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	46,304,345		6.00
7.00	Medicaid cost (line 1 times line 6)	14,857,397		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	2,796,119		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	0		9.00
10.00	Stand-alone CHIP charges	0		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0		12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care	0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,796,119		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,769,597	410,485	2,180,082 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	567,800	410,485	978,285 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)	567,800	410,485	978,285 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)	2,392,682		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	873,079		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,343,199		27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,049,483		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	806,861		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,785,146		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,581,265		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0115

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

Worksheet A

Date/Time Prepared:
11/29/2019 2:06 pm

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		3,863,826	3,863,826	-1,002,097	2,861,729	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	1,371,812	1,371,812	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	90,039	3,498,354	3,588,393	0	3,588,393	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,505,648	10,310,540	14,816,188	-184,087	14,632,101	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	515,678	1,665,713	2,181,391	0	2,181,391	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	171,374	171,374	8.00
9.00	00900	HOUSEKEEPING	0	659,638	659,638	0	659,638	9.00
10.00	01000	DIETARY	578,678	838,820	1,417,498	-295,655	1,121,843	10.00
11.00	01100	CAFETERIA	0	0	0	295,655	295,655	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	371,036	100,023	471,059	0	471,059	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	93,410	176,510	269,920	-141,199	128,721	14.00
15.00	01500	PHARMACY	712,134	3,667,244	4,379,378	-3,569,416	809,962	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	481,467	220,045	701,512	-33	701,479	16.00
17.00	01700	SOCIAL SERVICE	317,851	12,498	330,349	-2,735	327,614	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,091,196	1,026,387	6,117,583	-192,782	5,924,801	30.00
31.00	03100	INTENSIVE CARE UNIT	446,292	41,808	488,100	-8,783	479,317	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	641,165	1,206,902	1,848,067	-388,979	1,459,088	50.00
53.00	05300	ANESTHESIOLOGY	0	540,509	540,509	-17,981	522,528	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	795,122	687,005	1,482,127	-47,874	1,434,253	54.00
54.01	03630	ULTRASOUND	156,133	19,463	175,596	-15,343	160,253	54.01
60.00	06000	LABORATORY	1,112,215	1,842,206	2,954,421	-11,641	2,942,780	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	499,673	115,563	615,236	-38,894	576,342	65.00
66.00	06600	PHYSICAL THERAPY	0	142,655	142,655	0	142,655	66.00
69.00	06900	ELECTROCARDIOLOGY	71,373	34,390	105,763	-3,769	101,994	69.00
69.01	03140	CARDIAC CATH LAB	2,647	47,643	50,290	-24,904	25,386	69.01
70.01	07001	SLEEP LAB	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	856,183	856,183	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	293,982	293,982	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,531,611	3,531,611	73.00
74.00	07400	RENAL DIALYSIS	0	151,556	151,556	0	151,556	74.00
75.00	07500	ASC (NON-DISTINCT PART)	281,104	21,614	302,718	-16,001	286,717	75.00
75.01	03480	ONCOLOGY	344,995	116,420	461,415	-29,886	431,529	75.01
75.02	03340	GI LAB	0	111,188	111,188	-76,167	35,021	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,968,045	549,918	2,517,963	-11,292	2,506,671	90.00
90.01	09001	WOUND CARE CENTER	44,328	10,833	55,161	-10,293	44,868	90.01
91.00	09100	EMERGENCY	1,583,548	1,317,035	2,900,583	-73,804	2,826,779	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		357,002	357,002	-357,002	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,703,777	33,353,308	54,057,085	0	54,057,085	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	SENIOR HEALTH	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,651,942	1,542,800	3,194,742	0	3,194,742	192.00
192.01	19201	RETAIL PHARMACY	201,567	835,366	1,036,933	0	1,036,933	192.01
192.02	19202	CHA SITES	60,564	16,147	76,711	0	76,711	192.02
192.03	19203	OTHER NON REIMBURSABLE	0	17,663	17,663	0	17,663	192.03
194.00	07950	SENIOR HEALTH	3,337	0	3,337	0	3,337	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	22,621,187	35,765,284	58,386,471	0	58,386,471	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0115

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

Worksheet A

Date/Time Prepared:
11/29/2019 2:06 pm

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-6,296	2,855,433	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,371,812	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-9,984	3,578,409	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-4,172,629	10,459,472	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	2,181,391	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	171,374	8.00
9.00	00900	HOUSEKEEPING	0	659,638	9.00
10.00	01000	DIETARY	0	1,121,843	10.00
11.00	01100	CAFETERIA	-89,237	206,418	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	471,059	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	128,721	14.00
15.00	01500	PHARMACY	0	809,962	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,900	698,579	16.00
17.00	01700	SOCIAL SERVICE	-81,733	245,881	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	5,924,801	30.00
31.00	03100	INTENSIVE CARE UNIT	0	479,317	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-58,712	1,400,376	50.00
53.00	05300	ANESTHESIOLOGY	0	522,528	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,434,253	54.00
54.01	03630	ULTRASOUND	0	160,253	54.01
60.00	06000	LABORATORY	0	2,942,780	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	-6,991	569,351	65.00
66.00	06600	PHYSICAL THERAPY	0	142,655	66.00
69.00	06900	ELECTROCARDIOLOGY	0	101,994	69.00
69.01	03140	CARDIAC CATH LAB	0	25,386	69.01
70.01	07001	SLEEP LAB	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	856,183	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	293,982	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,531,611	73.00
74.00	07400	RENAL DIALYSIS	0	151,556	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	286,717	75.00
75.01	03480	ONCOLOGY	-83,440	348,089	75.01
75.02	03340	GI LAB	0	35,021	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-1,452,086	1,054,585	90.00
90.01	09001	WOUND CARE CENTER	0	44,868	90.01
91.00	09100	EMERGENCY	-802,222	2,024,557	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-6,766,230	47,290,855	118.00
NONREIMBURSABLE COST CENTERS					
190.01	19001	SENIOR HEALTH	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,194,742	192.00
192.01	19201	RETAIL PHARMACY	0	1,036,933	192.01
192.02	19202	CHA SITES	0	76,711	192.02
192.03	19203	OTHER NON REIMBURSABLE	0	17,663	192.03
194.00	07950	SENIOR HEALTH	0	3,337	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-6,766,230	51,620,241	200.00

RECLASSIFICATIONS

Provider CCN: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet A-6
Date/Time Prepared:
11/29/2019 2:06 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - DEPRECIATION GL CC 8850-8581				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,371,812	1.00
	TOTALS		0	1,371,812	
	B - INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	12,713	1.00
	TOTALS		0	12,713	
	C - DRUGS CHARGED				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,531,611	1.00
	TOTALS		0	3,531,611	
	D - SUPPLIES CHARGED				
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	856,183	1.00
	PATIENT				
2.00	IMPL. DEV. CHARGED TO	72.00	0	293,982	2.00
	PATIENTS				
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
	TOTALS		0	1,150,165	
	E - CAFETERIA COSTS				
1.00	CAFETERIA	11.00	120,698	174,957	1.00
	TOTALS		120,698	174,957	
	F - INTEREST				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	357,002	1.00
	TOTALS		0	357,002	
	I - LAUNDRY EXP				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	171,374	1.00
	TOTALS		0	171,374	
500.00	Grand Total: Increases		120,698	6,769,634	500.00

RECLASSIFICATIONS

Provider CCN: 14-0115

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

Worksheet A-6

Date/Time Prepared:
11/29/2019 2:06 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DEPRECIATION GL CC 8850-8581						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,371,812	9		1.00
	TOTALS		0	1,371,812			
	B - INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	12,713	12		1.00
	TOTALS		0	12,713			
	C - DRUGS CHARGED						
1.00	PHARMACY	15.00	0	3,531,611	0		1.00
	TOTALS		0	3,531,611			
	D - SUPPLIES CHARGED						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	141,199	0		1.00
2.00	PHARMACY	15.00	0	37,805	0		2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	0	33	0		3.00
4.00	SOCIAL SERVICE	17.00	0	2,735	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	192,782	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	8,783	0		6.00
7.00	OPERATING ROOM	50.00	0	388,979	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	17,981	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	47,874	0		9.00
10.00	ULTRASOUND	54.01	0	15,343	0		10.00
11.00	LABORATORY	60.00	0	11,641	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	38,894	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	3,769	0		13.00
14.00	CARDIAC CATH LAB	69.01	0	24,904	0		14.00
15.00	ASC (NON-DISTINCT PART)	75.00	0	16,001	0		15.00
16.00	ONCOLOGY	75.01	0	29,886	0		16.00
17.00	GI LAB	75.02	0	76,167	0		17.00
18.00	CLINIC	90.00	0	11,292	0		18.00
19.00	WOUND CARE CENTER	90.01	0	10,293	0		19.00
20.00	EMERGENCY	91.00	0	73,804	0		20.00
	TOTALS		0	1,150,165			
	E - CAFETERIA COSTS						
1.00	DIETARY	10.00	120,698	174,957	0		1.00
	TOTALS		120,698	174,957			
	F - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	357,002	11		1.00
	TOTALS		0	357,002			
	I - LAUNDRY EXP						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	171,374	0		1.00
	TOTALS		0	171,374			
500.00	Grand Total: Decreases		120,698	6,769,634			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part I
Date/Time Prepared:
11/29/2019 2:06 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	14,137,215	0	0	0	0	1.00	
2.00	Land Improvements	1,628,948	0	0	0	0	2.00	
3.00	Buildings and Fixtures	35,787,360	5,004,391	0	5,004,391	0	3.00	
4.00	Building Improvements	24,330,803	250,770	0	250,770	0	4.00	
5.00	Fixed Equipment	14,107,811	416,741	0	416,741	0	5.00	
6.00	Movable Equipment	26,763,963	364,913	0	364,913	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	116,756,100	6,036,815	0	6,036,815	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	116,756,100	6,036,815	0	6,036,815	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	14,137,215	0				1.00	
2.00	Land Improvements	1,628,948	0				2.00	
3.00	Buildings and Fixtures	40,791,751	0				3.00	
4.00	Building Improvements	24,581,573	0				4.00	
5.00	Fixed Equipment	14,524,552	0				5.00	
6.00	Movable Equipment	27,128,876	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	122,792,915	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	122,792,915	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part II
Date/Time Prepared:
11/29/2019 2:06 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	3,863,826	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,863,826	0	0	0	0	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	0	3,863,826				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	3,863,826				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part III
Date/Time Prepared:
11/29/2019 2:06 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	38,101,417	0	38,101,417	0.783925	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	10,501,951	0	10,501,951	0.216075	0	2.00
3.00	Total (sum of lines 1-2)	48,603,368	0	48,603,368	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	2,492,014	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,371,812	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,863,826	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	350,706	12,713	0	0	2,855,433	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,371,812	2.00
3.00	Total (sum of lines 1-2)	350,706	12,713	0	0	4,227,245	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0115

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

Worksheet A-8

Date/Time Prepared:
11/29/2019 2:06 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		B	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-6,296	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-17,586	ADMINISTRATIVE & GENERAL	5.00	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	-2,485,157			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-89,237	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-2,900	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0115

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

Worksheet A-8

Date/Time Prepared:
11/29/2019 2:06 pm

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
41.00 HOSPITALITY EXP	A	-135,867	ADMINISTRATIVE & GENERAL	5.00	0	41.00
41.01 HOSPITALITY EXP	A	-9,984	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	41.01
41.03 HOSPITALITY EXP	A	0	LABORATORY	60.00	0	41.03
41.05 HOSPITALITY EXP	A	-27	CLINIC	90.00	0	41.05
42.01 LDUES -LOBBYING PORTION	A	-11,242	ADMINISTRATIVE & GENERAL	5.00	0	42.01
42.02 MARKETING EXP	A	-81,350	ADMINISTRATIVE & GENERAL	5.00	0	42.02
42.03 MEDICARE PREMIUM FOR RETIRED EM	A	-4,300	ADMINISTRATIVE & GENERAL	5.00	0	42.03
44.00 ADVERTISING EXP	A	-18,154	ADMINISTRATIVE & GENERAL	5.00	0	44.00
44.02 ADVERTISING EXP	A	0		0.00	0	44.02
45.00 MEDICAID ASSESSMENT TAX	A	-3,904,130	ADMINISTRATIVE & GENERAL	5.00	0	45.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,766,230				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0115

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

Worksheet A-8-2

Date/Time Prepared:
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	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	4.00	AGGREGATE-EMPLOYEE BENEFITS DEPARTME	0	0	0	0	0	1.00
2.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	177,200	0	2.00
3.00	15.00	AGGREGATE-PHARMACY	0	0	0	0	0	3.00
4.00	16.00	AGGREGATE-MEDICAL RECORDS & LIBRARY	0	0	0	177,200	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	17.00	AGGREGATE-SOCIAL SERVICE	198,872	0	198,872	177,200	1,375	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	177,200	0	8.00
9.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	177,200	0	9.00
10.00	50.00	AGGREGATE-OPERATING ROOM	58,712	58,712	0	177,200	0	10.00
12.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	177,200	0	12.00
13.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	13.00
16.00	60.00	AGGREGATE-LABORATORY	0	0	0	177,200	0	16.00
18.00	65.00	AGGREGATE-RESPIRATORY THERAPY	6,991	6,991	0	177,200	0	18.00
20.00	75.01	AGGREGATE-ONCOLOGY	83,440	83,440	0	177,200	0	20.00
22.00	90.00	AGGREGATE-CLINIC	1,452,059	1,452,059	0	177,200	0	22.00
24.00	91.00	AGGREGATE-EMERGENCY	802,222	802,222	0	177,200	0	24.00
200.00			2,602,296	2,403,424	198,872		1,375	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	4.00	AGGREGATE-EMPLOYEE BENEFITS DEPARTME	0	0	0	0	0	1.00
2.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	0	0	2.00
3.00	15.00	AGGREGATE-PHARMACY	0	0	0	0	0	3.00
4.00	16.00	AGGREGATE-MEDICAL RECORDS & LIBRARY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	17.00	AGGREGATE-SOCIAL SERVICE	117,139	5,857	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	8.00
9.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	0	0	9.00
10.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	10.00
12.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	0	0	12.00
13.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	13.00
16.00	60.00	AGGREGATE-LABORATORY	0	0	0	0	0	16.00
18.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	0	0	18.00
20.00	75.01	AGGREGATE-ONCOLOGY	0	0	0	0	0	20.00
22.00	90.00	AGGREGATE-CLINIC	0	0	0	0	0	22.00
24.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	24.00
200.00			117,139	5,857	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	4.00	AGGREGATE-EMPLOYEE BENEFITS DEPARTME	0	0	0	0		1.00
2.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	0		2.00
3.00	15.00	AGGREGATE-PHARMACY	0	0	0	0		3.00
4.00	16.00	AGGREGATE-MEDICAL RECORDS & LIBRARY	0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	17.00	AGGREGATE-SOCIAL SERVICE	0	117,139	81,733	81,733		6.00
7.00	0.00		0	0	0	0		7.00
8.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0		8.00
9.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	0		9.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0115

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

Worksheet A-8-2

Date/Time Prepared:
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	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		
10.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	58,712		10.00
12.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	0		12.00
13.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0		13.00
16.00	60.00	AGGREGATE-LABORATORY	0	0	0	0		16.00
18.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	6,991		18.00
20.00	75.01	AGGREGATE-ONCOLOGY	0	0	0	83,440		20.00
22.00	90.00	AGGREGATE-CLINIC	0	0	0	1,452,059		22.00
24.00	91.00	AGGREGATE-EMERGENCY	0	0	0	802,222		24.00
200.00			0	117,139	81,733	2,485,157		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/29/2019 2:06 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,855,433	2,855,433			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,371,812	1,371,812			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,578,409	4,460	2,143	3,585,012	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,459,472	161,414	77,547	716,912	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	2,181,391	602,218	289,318	82,052	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	171,374	0	0	0	8.00
9.00	00900	HOUSEKEEPING	659,638	9,019	4,333	0	9.00
10.00	01000	DIETARY	1,121,843	76,996	36,991	72,871	10.00
11.00	01100	CAFETERIA	206,418	33,834	16,254	19,205	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	471,059	0	0	59,037	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	128,721	94,056	45,186	14,863	14.00
15.00	01500	PHARMACY	809,962	12,389	5,952	113,310	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	698,579	37,018	17,784	76,608	16.00
17.00	01700	SOCIAL SERVICE	245,881	0	0	50,575	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,924,801	521,395	250,490	810,070	30.00
31.00	03100	INTENSIVE CARE UNIT	479,317	39,471	18,963	71,011	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,400,376	92,321	44,353	102,018	50.00
53.00	05300	ANESTHESIOLOGY	522,528	4,002	1,922	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,434,253	107,882	51,829	126,515	54.00
54.01	03630	ULTRASOUND	160,253	2,787	1,339	24,843	54.01
60.00	06000	LABORATORY	2,942,780	67,928	32,634	176,969	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	569,351	37,204	17,873	79,505	65.00
66.00	06600	PHYSICAL THERAPY	142,655	32,137	15,439	0	66.00
69.00	06900	ELECTROCARDIOLOGY	101,994	2,416	1,161	11,356	69.00
69.01	03140	CARDIAC CATH LAB	25,386	19,203	9,225	421	69.01
70.01	07001	SLEEP LAB	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	856,183	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	293,982	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,531,611	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	151,556	867	417	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	286,717	101,489	48,758	44,728	75.00
75.01	03480	ONCOLOGY	348,089	56,171	26,986	54,894	75.01
75.02	03340	GI LAB	35,021	22,275	10,701	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,054,585	72,549	34,854	313,144	90.00
90.01	09001	WOUND CARE CENTER	44,868	10,530	5,059	7,053	90.01
91.00	09100	EMERGENCY	2,024,557	42,741	20,534	251,965	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	47,290,855	2,264,772	1,088,045	3,279,925	118.00
NONREIMBURSABLE COST CENTERS							
190.01	19001	SENIOR HEALTH	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,194,742	15,783	7,583	262,847	192.00
192.01	19201	RETAIL PHARMACY	1,036,933	4,460	2,143	32,072	192.01
192.02	19202	CHA SITES	76,711	570,418	274,041	9,637	192.02
192.03	19203	OTHER NON REIMBURSABLE	17,663	0	0	0	192.03
194.00	07950	SENIOR HEALTH	3,337	0	0	531	194.00
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
202.00 TOTAL (sum lines 118 through 201)	51,620,241	2,855,433	1,371,812	3,585,012	51,620,241	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
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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	11,415,345					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	895,790	0	4,050,769			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	48,658	0	0	220,032		8.00
9.00	00900	HOUSEKEEPING	191,081	0	17,503	0	881,574	9.00
10.00	01000	DIETARY	371,578	0	149,422	0	32,591	10.00
11.00	01100	CAFETERIA	78,282	0	65,659	0	14,321	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	150,510	0	0	0	1,872	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	80,303	0	182,528	0	39,811	14.00
15.00	01500	PHARMACY	267,351	0	24,042	0	5,244	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	235,658	0	71,838	0	15,669	16.00
17.00	01700	SOCIAL SERVICE	84,172	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,131,396	0	1,011,839	156,265	220,694	30.00
31.00	03100	INTENSIVE CARE UNIT	172,845	0	76,598	4,178	16,707	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	465,379	0	179,162	29,439	39,077	50.00
53.00	05300	ANESTHESIOLOGY	150,043	0	7,766		1,694	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	488,494	0	209,359	19,978	45,664	54.00
54.01	03630	ULTRASOUND	53,726	0	5,409	0	1,180	54.01
60.00	06000	LABORATORY	914,340	0	131,823	0	28,752	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	199,867	0	72,199		15,747	65.00
66.00	06600	PHYSICAL THERAPY	54,012	0	62,365	0	13,603	66.00
69.00	06900	ELECTROCARDIOLOGY	33,199	0	4,688	0	1,023	69.00
69.01	03140	CARDIAC CATH LAB	15,399	0	37,265	0	8,128	69.01
70.01	07001	SLEEP LAB	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	243,095	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	83,470	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,002,727	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	43,396	0	1,683	0	367	74.00
75.00	07500	ASC (NON-DISTINCT PART)	136,766	0	196,953	10,039	42,958	75.00
75.01	03480	ONCOLOGY	138,029	0	109,007	0	23,776	75.01
75.02	03340	GI LAB	19,306	0	43,228	0	9,428	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	418,833	0	140,791	0	30,708	90.00
90.01	09001	WOUND CARE CENTER	19,168	0	20,436	0	4,457	90.01
91.00	09100	EMERGENCY	664,336	0	82,945	133	18,091	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,851,209	0	2,904,508	220,032	631,562	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	SENIOR HEALTH	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	988,344	0	30,630	0	6,681	192.00
192.01	19201	RETAIL PHARMACY	305,396	0	8,655	0	1,888	192.01
192.02	19202	CHA SITES	264,283	0	1,106,976	0	241,443	192.02
192.03	19203	OTHER NON REIMBURSABLE	5,015	0	0	0	0	192.03
194.00	07950	SENIOR HEALTH	1,098	0	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)	11,415,345	0	4,050,769	220,032	881,574	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	1,862,292					10.00
11.00	01100	CAFETERIA	0	433,973				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	7,508	0	689,986		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,833	0	0	590,301	14.00
15.00	01500	PHARMACY	0	12,524	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	16,621	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	2,943	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,841,832	171,078	0	490,225	0	30.00
31.00	03100	INTENSIVE CARE UNIT	20,460	10,016	0	28,702	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	15,484	0	44,370	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,879	0	0	0	54.00
54.01	03630	ULTRASOUND	0	7,826	0	0	0	54.01
60.00	06000	LABORATORY	0	41,871	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	14,347	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,739	0	0	0	69.00
69.01	03140	CARDIAC CATH LAB	0	67	0	0	0	69.01
70.01	07001	SLEEP LAB	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	439,420	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	150,881	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	6,220	0	17,825	0	75.00
75.01	03480	ONCOLOGY	0	9,046	0	25,922	0	75.01
75.02	03340	GI LAB	0	0	0	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	27,908	0	0	0	90.00
90.01	09001	WOUND CARE CENTER	0	1,204	0	3,450	0	90.01
91.00	09100	EMERGENCY	0	27,741	0	79,492	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,862,292	397,855	0	689,986	590,301	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	SENIOR HEALTH	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	27,858	0	0	0	192.00
192.01	19201	RETAIL PHARMACY	0	4,582	0	0	0	192.01
192.02	19202	CHA SITES	0	3,394	0	0	0	192.02
192.03	19203	OTHER NON REIMBURSABLE	0	0	0	0	0	192.03
194.00	07950	SENIOR HEALTH	0	284	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)	1,862,292	433,973	0	689,986	590,301	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet B
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	1,250,774					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,169,775				16.00
17.00	01700	SOCIAL SERVICE	0	0	383,571			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	279,051	230,143	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	8,280	76,714	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	22,405	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	9,629	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,075	112,009	0	0	0	54.00
54.01	03630	ULTRASOUND	0	20,295	0	0	0	54.01
60.00	06000	LABORATORY	0	223,468	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	69,651	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,390	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	20,980	0	0	0	69.00
69.01	03140	CARDIAC CATH LAB	0	1,722	0	0	0	69.01
70.01	07001	SLEEP LAB	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	38,182	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	16,203	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,013,369	226,280	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	3,883	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	12,960	0	0	0	75.00
75.01	03480	ONCOLOGY	0	21,217	38,357	0	0	75.01
75.02	03340	GI LAB	0	11,282	0	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	12,228	0	0	0	90.00
90.01	09001	WOUND CARE CENTER	0	1,923	0	0	0	90.01
91.00	09100	EMERGENCY	0	56,737	38,357	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,025,444	1,169,775	383,571	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	SENIOR HEALTH	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	RETAIL PHARMACY	225,330	0	0	0	0	192.01
192.02	19202	CHA SITES	0	0	0	0	0	192.02
192.03	19203	OTHER NON REIMBURSABLE	0	0	0	0	0	192.03
194.00	07950	SENIOR HEALTH	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,250,774	1,169,775	383,571	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet B
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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	14,039,279	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	1,023,262	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	2,434,384	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	697,584	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,626,937	0	54.00
54.01	03630	ULTRASOUND	0	0	0	277,658	0	54.01
60.00	06000	LABORATORY	0	0	0	4,560,565	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,075,744	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	321,601	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	178,556	0	69.00
69.01	03140	CARDIAC CATH LAB	0	0	0	116,816	0	69.01
70.01	07001	SLEEP LAB	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,576,880	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	544,536	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,773,987	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	202,169	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	905,413	0	75.00
75.01	03480	ONCOLOGY	0	0	0	851,494	0	75.01
75.02	03340	GI LAB	0	0	0	151,241	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	2,105,600	0	90.00
90.01	09001	WOUND CARE CENTER	0	0	0	118,148	0	90.01
91.00	09100	EMERGENCY	0	0	0	3,307,629	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	42,889,483	0	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	SENIOR HEALTH	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	4,534,468	0	192.00
192.01	19201	RETAIL PHARMACY	0	0	0	1,621,459	0	192.01
192.02	19202	CHA SITES	0	0	0	2,546,903	0	192.02
192.03	19203	OTHER NON REIMBURSABLE	0	0	0	22,678	0	192.03
194.00	07950	SENIOR HEALTH	0	0	0	5,250	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
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Cost Center Description	INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
	21.00	22.00		23.00	24.00	25.00
202.00	TOTAL (sum lines 118 through 201)	0	0	0	51,620,241	0
						202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0115

Period:
From 07/01/2018
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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
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
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
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	03630	ULTRASOUND	54.01
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
69.01	03140	CARDIAC CATH LAB	69.01
70.01	07001	SLEEP LAB	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
75.00	07500	ASC (NON-DISTINCT PART)	75.00
75.01	03480	ONCOLOGY	75.01
75.02	03340	GI LAB	75.02
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
90.01	09001	WOUND CARE CENTER	90.01
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	99.40
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			
190.01	19001	SENIOR HEALTH	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	RETAIL PHARMACY	192.01
192.02	19202	CHA SITES	192.02
192.03	19203	OTHER NON REIMBURSABLE	192.03
194.00	07950	SENIOR HEALTH	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: 14-0115

Period:
From 07/01/2018
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Part II
Date/Time Prepared:
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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	4,460	2,143	6,603	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	161,414	77,547	238,961	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	602,218	289,318	891,536	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	9,019	4,333	13,352	9.00
10.00	01000	DIETARY	0	76,996	36,991	113,987	10.00
11.00	01100	CAFETERIA	0	33,834	16,254	50,088	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	109	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	94,056	45,186	139,242	14.00
15.00	01500	PHARMACY	0	12,389	5,952	18,341	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	37,018	17,784	54,802	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	93	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	521,395	250,490	771,885	30.00
31.00	03100	INTENSIVE CARE UNIT	0	39,471	18,963	58,434	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	92,321	44,353	136,674	50.00
53.00	05300	ANESTHESIOLOGY	0	4,002	1,922	5,924	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	107,882	51,829	159,711	54.00
54.01	03630	ULTRASOUND	0	2,787	1,339	4,126	54.01
60.00	06000	LABORATORY	0	67,928	32,634	100,562	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	37,204	17,873	55,077	65.00
66.00	06600	PHYSICAL THERAPY	0	32,137	15,439	47,576	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,416	1,161	3,577	69.00
69.01	03140	CARDIAC CATH LAB	0	19,203	9,225	28,428	69.01
70.01	07001	SLEEP LAB	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	867	417	1,284	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	101,489	48,758	150,247	75.00
75.01	03480	ONCOLOGY	0	56,171	26,986	83,157	75.01
75.02	03340	GI LAB	0	22,275	10,701	32,976	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	72,549	34,854	107,403	90.00
90.01	09001	WOUND CARE CENTER	0	10,530	5,059	15,589	90.01
91.00	09100	EMERGENCY	0	42,741	20,534	63,275	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,264,772	1,088,045	3,352,817	118.00
NONREIMBURSABLE COST CENTERS							
190.01	19001	SENIOR HEALTH	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	15,783	7,583	23,366	192.00
192.01	19201	RETAIL PHARMACY	0	4,460	2,143	6,603	192.01
192.02	19202	CHA SITES	0	570,418	274,041	844,459	192.02
192.03	19203	OTHER NON REIMBURSABLE	0	0	0	0	192.03
194.00	07950	SENIOR HEALTH	0	0	0	1	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	2,855,433	1,371,812	4,227,245	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
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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	240,281					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	18,854	0	910,541			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,024	0	0	1,024		8.00
9.00	00900	HOUSEKEEPING	4,022	0	3,934	0	21,308	9.00
10.00	01000	DIETARY	7,821	0	33,587	0	788	10.00
11.00	01100	CAFETERIA	1,648	0	14,759	0	346	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	3,168	0	0	0	45	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,690	0	41,029	0	962	14.00
15.00	01500	PHARMACY	5,627	0	5,404	0	127	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,960	0	16,148	0	379	16.00
17.00	01700	SOCIAL SERVICE	1,772	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	44,874	0	227,443	727	5,334	30.00
31.00	03100	INTENSIVE CARE UNIT	3,638	0	17,218	19	404	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,795	0	40,272	137	945	50.00
53.00	05300	ANESTHESIOLOGY	3,158	0	1,746		41	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,282	0	47,060	93	1,104	54.00
54.01	03630	ULTRASOUND	1,131	0	1,216	0	29	54.01
60.00	06000	LABORATORY	19,245	0	29,632	0	695	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	4,207	0	16,229	0	381	65.00
66.00	06600	PHYSICAL THERAPY	1,137	0	14,019	0	329	66.00
69.00	06900	ELECTROCARDIOLOGY	699	0	1,054	0	25	69.00
69.01	03140	CARDIAC CATH LAB	324	0	8,377	0	196	69.01
70.01	07001	SLEEP LAB	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,117	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,757	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,105	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	913	0	378	0	9	74.00
75.00	07500	ASC (NON-DISTINCT PART)	2,879	0	44,272	47	1,038	75.00
75.01	03480	ONCOLOGY	2,905	0	24,503		575	75.01
75.02	03340	GI LAB	406	0	9,717	0	228	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	8,815	0	31,647	0	742	90.00
90.01	09001	WOUND CARE CENTER	403	0	4,594	0	108	90.01
91.00	09100	EMERGENCY	13,983	0	18,645	1	437	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	207,359	0	652,883	1,024	15,267	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	SENIOR HEALTH	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,802	0	6,885	0	161	192.00
192.01	19201	RETAIL PHARMACY	6,428	0	1,946	0	46	192.01
192.02	19202	CHA SITES	5,563	0	248,827	0	5,834	192.02
192.03	19203	OTHER NON REIMBURSABLE	106	0	0	0	0	192.03
194.00	07950	SENIOR HEALTH	23	0	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)	240,281	0	910,541	1,024	21,308	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0115

Period:
From 07/01/2018
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	156,317					10.00
11.00	01100	CAFETERIA	0	66,876				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	1,157	0	4,479		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	745	0	0	183,695	14.00
15.00	01500	PHARMACY	0	1,930	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,561	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	454	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	154,600	26,362	0	3,183	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,717	1,544	0	186	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,386	0	288	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,909	0	0	0	54.00
54.01	03630	ULTRASOUND	0	1,206	0	0	0	54.01
60.00	06000	LABORATORY	0	6,452	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	2,211	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	268	0	0	0	69.00
69.01	03140	CARDIAC CATH LAB	0	10	0	0	0	69.01
70.01	07001	SLEEP LAB	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	136,743	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	46,952	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	959	0	116	0	75.00
75.01	03480	ONCOLOGY	0	1,394	0	168	0	75.01
75.02	03340	GI LAB	0	0	0	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	4,301	0	0	0	90.00
90.01	09001	WOUND CARE CENTER	0	186	0	22	0	90.01
91.00	09100	EMERGENCY	0	4,275	0	516	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	156,317	61,310	0	4,479	183,695	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	SENIOR HEALTH	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,293	0	0	0	192.00
192.01	19201	RETAIL PHARMACY	0	706	0	0	0	192.01
192.02	19202	CHA SITES	0	523	0	0	0	192.02
192.03	19203	OTHER NON REIMBURSABLE	0	0	0	0	0	192.03
194.00	07950	SENIOR HEALTH	0	44	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)	156,317	66,876	0	4,479	183,695	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	31,638					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	78,991				16.00
17.00	01700	SOCIAL SERVICE	0	0	2,319			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	18,835	1,391			30.00
31.00	03100	INTENSIVE CARE UNIT	0	559	464			31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,513	0			50.00
53.00	05300	ANESTHESIOLOGY	0	650	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	305	7,565	0			54.00
54.01	03630	ULTRASOUND	0	1,371	0			54.01
60.00	06000	LABORATORY	0	15,092	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
65.00	06500	RESPIRATORY THERAPY	0	4,704	0			65.00
66.00	06600	PHYSICAL THERAPY	0	94	0			66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,417	0			69.00
69.01	03140	CARDIAC CATH LAB	0	116	0			69.01
70.01	07001	SLEEP LAB	0	0	0			70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,579	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,094	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,633	15,282	0			73.00
74.00	07400	RENAL DIALYSIS	0	262	0			74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	875	0			75.00
75.01	03480	ONCOLOGY	0	1,433	232			75.01
75.02	03340	GI LAB	0	762	0			75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	826	0			90.00
90.01	09001	WOUND CARE CENTER	0	130	0			90.01
91.00	09100	EMERGENCY	0	3,832	232			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,938	78,991	2,319	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	SENIOR HEALTH	0	0	0			190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0			192.00
192.01	19201	RETAIL PHARMACY	5,700	0	0			192.01
192.02	19202	CHA SITES	0	0	0			192.02
192.03	19203	OTHER NON REIMBURSABLE	0	0	0			192.03
194.00	07950	SENIOR HEALTH	0	0	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)	31,638	78,991	2,319	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0115

Period:
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Part II
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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				1,256,127	0	30.00
31.00	03100	INTENSIVE CARE UNIT				84,314	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				192,198	0	50.00
53.00	05300	ANESTHESIOLOGY				11,519	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				229,262	0	54.00
54.01	03630	ULTRASOUND				9,125	0	54.01
60.00	06000	LABORATORY				172,004	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
65.00	06500	RESPIRATORY THERAPY				82,955	0	65.00
66.00	06600	PHYSICAL THERAPY				63,155	0	66.00
69.00	06900	ELECTROCARDIOLOGY				7,061	0	69.00
69.01	03140	CARDIAC CATH LAB				37,452	0	69.01
70.01	07001	SLEEP LAB				0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				144,439	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				49,803	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				62,020	0	73.00
74.00	07400	RENAL DIALYSIS				2,846	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)				200,515	0	75.00
75.01	03480	ONCOLOGY				114,468	0	75.01
75.02	03340	GI LAB				44,089	0	75.02
76.97	07697	CARDIAC REHABILITATION				0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				0	0	76.98
76.99	07699	LITHOTRIPSY				0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC				154,311	0	90.00
90.01	09001	WOUND CARE CENTER				21,045	0	90.01
91.00	09100	EMERGENCY				105,660	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF				0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	3,044,368	0	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	SENIOR HEALTH				0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES				55,991	0	192.00
192.01	19201	RETAIL PHARMACY				21,488	0	192.01
192.02	19202	CHA SITES				1,105,224	0	192.02
192.03	19203	OTHER NON REIMBURSABLE				106	0	192.03
194.00	07950	SENIOR HEALTH				68	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/29/2019 2:06 pm

Cost Center Description	INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
	21.00	22.00		23.00	24.00	25.00
202.00	TOTAL (sum lines 118 through 201)	0	0	0	4,227,245	0
						202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/29/2019 2:06 pm

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
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
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
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	03630	ULTRASOUND	54.01
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
69.01	03140	CARDIAC CATH LAB	69.01
70.01	07001	SLEEP LAB	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
75.00	07500	ASC (NON-DISTINCT PART)	75.00
75.01	03480	ONCOLOGY	75.01
75.02	03340	GI LAB	75.02
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
90.01	09001	WOUND CARE CENTER	90.01
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	99.40
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			
190.01	19001	SENIOR HEALTH	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	RETAIL PHARMACY	192.01
192.02	19202	CHA SITES	192.02
192.03	19203	OTHER NON REIMBURSABLE	192.03
194.00	07950	SENIOR HEALTH	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: 14-0115

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

Worksheet B-1

Date/Time Prepared:
11/29/2019 2:06 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	230,485					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		230,485				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	360	360	22,531,148			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,029	13,029	4,505,648	-11,415,345	40,204,896	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	48,610	48,610	515,678	0	3,154,979	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	171,374	8.00
9.00	00900	HOUSEKEEPING	728	728	0	0	672,990	9.00
10.00	01000	DIETARY	6,215	6,215	457,980	0	1,308,701	10.00
11.00	01100	CAFETERIA	2,731	2,731	120,698	0	275,711	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	371,036	0	530,096	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,592	7,592	93,410	0	282,826	14.00
15.00	01500	PHARMACY	1,000	1,000	712,134	0	941,613	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,988	2,988	481,467	0	829,989	16.00
17.00	01700	SOCIAL SERVICE	0	0	317,851	0	296,456	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	42,086	42,086	5,091,196	0	7,506,756	30.00
31.00	03100	INTENSIVE CARE UNIT	3,186	3,186	446,292	0	608,762	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,452	7,452	641,165	0	1,639,068	50.00
53.00	05300	ANESTHESIOLOGY	323	323	0	0	528,452	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,708	8,708	795,122	0	1,720,479	54.00
54.01	03630	ULTRASOUND	225	225	156,133	0	189,222	54.01
60.00	06000	LABORATORY	5,483	5,483	1,112,215	0	3,220,311	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	3,003	3,003	499,673	0	703,933	65.00
66.00	06600	PHYSICAL THERAPY	2,594	2,594	0	0	190,231	66.00
69.00	06900	ELECTROCARDIOLOGY	195	195	71,373	0	116,927	69.00
69.01	03140	CARDIAC CATH LAB	1,550	1,550	2,647	0	54,235	69.01
70.01	07001	SLEEP LAB	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	856,183	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	293,982	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,531,611	73.00
74.00	07400	RENAL DIALYSIS	70	70	0	0	152,840	74.00
75.00	07500	ASC (NON-DISTINCT PART)	8,192	8,192	281,104	0	481,692	75.00
75.01	03480	ONCOLOGY	4,534	4,534	344,995	0	486,140	75.01
75.02	03340	GI LAB	1,798	1,798	0	0	67,997	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	5,856	5,856	1,968,045	0	1,475,132	90.00
90.01	09001	WOUND CARE CENTER	850	850	44,328	0	67,510	90.01
91.00	09100	EMERGENCY	3,450	3,450	1,583,548	0	2,339,797	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	182,808	182,808	20,613,738	-11,415,345	34,695,995	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	SENIOR HEALTH	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,274	1,274	1,651,942	0	3,480,955	192.00
192.01	19201	RETAIL PHARMACY	360	360	201,567	0	1,075,608	192.01
192.02	19202	CHA SITES	46,043	46,043	60,564	0	930,807	192.02
192.03	19203	OTHER NON REIMBURSABLE	0	0	0	0	17,663	192.03
194.00	07950	SENIOR HEALTH	0	0	3,337	0	3,868	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0115

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

Worksheet B-1

Date/Time Prepared:
11/29/2019 2:06 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	2,855,433	1,371,812	3,585,012		11,415,345	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.388802	5.951849	0.159114		0.283929	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			6,603		240,281	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000293		0.005976	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: 14-0115

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

Worksheet B-1

Date/Time Prepared:
11/29/2019 2:06 pm

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	0					6.00
7.00	00700	OPERATION OF PLANT	0	168,486				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	315,278			8.00
9.00	00900	HOUSEKEEPING	0	728	0	168,115		9.00
10.00	01000	DIETARY	0	6,215	0	6,215	84,102	10.00
11.00	01100	CAFETERIA	0	2,731	0	2,731	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	357	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,592	0	7,592	0	14.00
15.00	01500	PHARMACY	0	1,000	0	1,000	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,988	0	2,988	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	42,086	223,907	42,086	83,178	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,186	5,986	3,186	924	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	7,452	42,183	7,452	0	50.00
53.00	05300	ANESTHESIOLOGY	0	323	0	323	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,708	28,626	8,708	0	54.00
54.01	03630	ULTRASOUND	0	225	0	225	0	54.01
60.00	06000	LABORATORY	0	5,483	0	5,483	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	3,003	0	3,003	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,594	0	2,594	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	195	0	195	0	69.00
69.01	03140	CARDIAC CATH LAB	0	1,550	0	1,550	0	69.01
70.01	07001	SLEEP LAB	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	70	0	70	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	8,192	14,385	8,192	0	75.00
75.01	03480	ONCOLOGY	0	4,534	0	4,534	0	75.01
75.02	03340	GI LAB	0	1,798	0	1,798	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	5,856	0	5,856	0	90.00
90.01	09001	WOUND CARE CENTER	0	850	0	850	0	90.01
91.00	09100	EMERGENCY	0	3,450	191	3,450	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	120,809	315,278	120,438	84,102	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	SENIOR HEALTH	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,274	0	1,274	0	192.00
192.01	19201	RETAIL PHARMACY	0	360	0	360	0	192.01
192.02	19202	CHA SITES	0	46,043	0	46,043	0	192.02
192.03	19203	OTHER NON REIMBURSABLE	0	0	0	0	0	192.03
194.00	07950	SENIOR HEALTH	0	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)	0	4,050,769	220,032	881,574	1,862,292	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	24.042170	0.697898	5.243875	22.143255	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0115

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

Worksheet B-1

Date/Time Prepared:
11/29/2019 2:06 pm

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	
204.00		Cost to be allocated (per Wkst. B, Part II)	0	910,541	1,024	21,308	156,317	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	5.404253	0.003248	0.126747	1.858660	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: 14-0115

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

Worksheet B-1

Date/Time Prepared:
11/29/2019 2:06 pm

Cost Center Description			CAFETERIA (FTE'S)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	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						10.00
11.00	01100	CAFETERIA	25,953					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	449	0	14,400			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	289	0	0	1,150,165		14.00
15.00	01500	PHARMACY	749	0	0	0	4,358,973	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	994	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	176	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,231	0	10,231	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	599	0	599	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	926	0	926	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,129	0	0		42,083	54.00
54.01	03630	ULTRASOUND	468	0	0	0	0	54.01
60.00	06000	LABORATORY	2,504	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	858	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	104	0	0	0	0	69.00
69.01	03140	CARDIAC CATH LAB	4	0	0	0	0	69.01
70.01	07001	SLEEP LAB	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	856,183	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	293,982	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,531,611	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	372	0	372	0	0	75.00
75.01	03480	ONCOLOGY	541	0	541	0	0	75.01
75.02	03340	GI LAB	0	0	0	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,669	0	0	0	0	90.00
90.01	09001	WOUND CARE CENTER	72	0	72	0	0	90.01
91.00	09100	EMERGENCY	1,659	0	1,659	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,793	0	14,400	1,150,165	3,573,694	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	SENIOR HEALTH	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,666	0	0	0	0	192.00
192.01	19201	RETAIL PHARMACY	274	0	0	0	785,279	192.01
192.02	19202	CHA SITES	203	0	0	0	0	192.02
192.03	19203	OTHER NON REIMBURSABLE	0	0	0	0	0	192.03
194.00	07950	SENIOR HEALTH	17	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)	433,973	0	689,986	590,301	1,250,774	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0115

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

Worksheet B-1

Date/Time Prepared:
11/29/2019 2:06 pm

Cost Center Description		CAFETERIA (FTE'S)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	16.721497	0.000000	47.915694	0.513232	0.286942	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	66,876	0	4,479	183,695	31,638	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	2.576812	0.000000	0.311042	0.159712	0.007258	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: 14-0115

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

Worksheet B-1

Date/Time Prepared:
11/29/2019 2:06 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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	133,668,797					16.00
17.00	01700	SOCIAL SERVICE	0	100				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	31,883,091	60	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	946,197	20	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,560,292	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1,100,381	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,799,600	0	0	0	0	54.00
54.01	03630	ULTRASOUND	2,319,214	0	0	0	0	54.01
60.00	06000	LABORATORY	25,536,316	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	7,959,184	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	158,842	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	2,397,443	0	0	0	0	69.00
69.01	03140	CARDIAC CATH LAB	196,773	0	0	0	0	69.01
70.01	07001	SLEEP LAB	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,363,158	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,851,576	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,857,621	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	443,757	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	1,480,982	0	0	0	0	75.00
75.01	03480	ONCOLOGY	2,424,550	10	0	0	0	75.01
75.02	03340	GI LAB	1,289,213	0	0	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,397,369	0	0	0	0	90.00
90.01	09001	WOUND CARE CENTER	219,796	0	0	0	0	90.01
91.00	09100	EMERGENCY	6,483,442	10	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	133,668,797	100	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	SENIOR HEALTH	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	RETAIL PHARMACY	0	0	0	0	0	192.01
192.02	19202	CHA SITES	0	0	0	0	0	192.02
192.03	19203	OTHER NON REIMBURSABLE	0	0	0	0	0	192.03
194.00	07950	SENIOR HEALTH	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0115

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

Worksheet B-1

Date/Time Prepared:
11/29/2019 2:06 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	1,169,775	383,571	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.008751	3,835.710000	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	78,991	2,319	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000591	23.190000	0.000000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0115

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

Worksheet B-1

Date/Time Prepared:
11/29/2019 2:06 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
			22.00		
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
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
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
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03630	ULTRASOUND	0	0	54.01
60.00	06000	LABORATORY	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
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
69.01	03140	CARDIAC CATH LAB	0	0	69.01
70.01	07001	SLEEP LAB	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
75.01	03480	ONCOLOGY	0	0	75.01
75.02	03340	GI LAB	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	09001	WOUND CARE CENTER	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	118.00
NONREIMBURSABLE COST CENTERS					
190.01	19001	SENIOR HEALTH	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	RETAIL PHARMACY	0	0	192.01
192.02	19202	CHA SITES	0	0	192.02
192.03	19203	OTHER NON REIMBURSABLE	0	0	192.03
194.00	07950	SENIOR HEALTH	0	0	194.00
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0115

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

Worksheet B-1

Date/Time Prepared:
11/29/2019 2:06 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
			22.00		
202.00		Cost to be allocated (per Wkst. B, Part I)	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/29/2019 2:06 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,039,279		14,039,279	0	14,039,279	30.00
31.00	03100	INTENSIVE CARE UNIT	1,023,262		1,023,262	0	1,023,262	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,434,384		2,434,384	0	2,434,384	50.00
53.00	05300	ANESTHESIOLOGY	697,584		697,584	0	697,584	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,626,937		2,626,937	0	2,626,937	54.00
54.01	03630	ULTRASOUND	277,658		277,658	0	277,658	54.01
60.00	06000	LABORATORY	4,560,565		4,560,565	0	4,560,565	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,075,744	0	1,075,744	0	1,075,744	65.00
66.00	06600	PHYSICAL THERAPY	321,601	0	321,601	0	321,601	66.00
69.00	06900	ELECTROCARDIOLOGY	178,556		178,556	0	178,556	69.00
69.01	03140	CARDIAC CATH LAB	116,816		116,816	0	116,816	69.01
70.01	07001	SLEEP LAB	0		0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,576,880		1,576,880	0	1,576,880	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	544,536		544,536	0	544,536	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,773,987		5,773,987	0	5,773,987	73.00
74.00	07400	RENAL DIALYSIS	202,169		202,169	0	202,169	74.00
75.00	07500	ASC (NON-DISTINCT PART)	905,413		905,413	0	905,413	75.00
75.01	03480	ONCOLOGY	851,494		851,494	0	851,494	75.01
75.02	03340	GI LAB	151,241		151,241	0	151,241	75.02
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,105,600		2,105,600	0	2,105,600	90.00
90.01	09001	WOUND CARE CENTER	118,148		118,148	0	118,148	90.01
91.00	09100	EMERGENCY	3,307,629		3,307,629	0	3,307,629	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	441,443		441,443	0	441,443	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0		0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	43,330,926	0	43,330,926	0	43,330,926	200.00
201.00		Less Observation Beds	441,443		441,443		441,443	201.00
202.00		Total (see instructions)	42,889,483	0	42,889,483	0	42,889,483	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-0115		Period: From 07/01/2018 To 06/30/2019		Worksheet C Part I Date/Time Prepared: 11/29/2019 2:06 pm		
				Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
			Inpatient	Outpatient	Total (col. 6 + col. 7)					
			6.00	7.00	8.00					
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	30,408,216		30,408,216				30.00	
31.00	03100	INTENSIVE CARE UNIT	946,197		946,197				31.00	
ANCILLARY SERVICE COST CENTERS										
50.00	05000	OPERATING ROOM	946,027	1,614,265	2,560,292	0.950823	0.000000		50.00	
53.00	05300	ANESTHESIOLOGY	365,017	735,364	1,100,381	0.633948	0.000000		53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,805,201	9,994,399	12,799,600	0.205236	0.000000		54.00	
54.01	03630	ULTRASOUND	523,895	1,795,319	2,319,214	0.119721	0.000000		54.01	
60.00	06000	LABORATORY	9,341,074	16,195,242	25,536,316	0.178591	0.000000		60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000		62.30	
65.00	06500	RESPIRATORY THERAPY	6,992,377	966,807	7,959,184	0.135158	0.000000		65.00	
66.00	06600	PHYSICAL THERAPY	155,826	3,016	158,842	2.024660	0.000000		66.00	
69.00	06900	ELECTROCARDIOLOGY	858,478	1,538,965	2,397,443	0.074478	0.000000		69.00	
69.01	03140	CARDIAC CATH LAB	22,246	174,527	196,773	0.593659	0.000000		69.01	
70.01	07001	SLEEP LAB	0	0	0	0.000000	0.000000		70.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,168,147	2,195,011	4,363,158	0.361408	0.000000		71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,601,428	250,148	1,851,576	0.294093	0.000000		72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	11,414,894	14,442,727	25,857,621	0.223299	0.000000		73.00	
74.00	07400	RENAL DIALYSIS	363,230	80,527	443,757	0.455585	0.000000		74.00	
75.00	07500	ASC (NON-DISTINCT PART)	237,255	1,243,727	1,480,982	0.611360	0.000000		75.00	
75.01	03480	ONCOLOGY	37,969	2,386,581	2,424,550	0.351197	0.000000		75.01	
75.02	03340	GI LAB	202,980	1,086,233	1,289,213	0.117313	0.000000		75.02	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000		76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000		76.98	
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000		76.99	
OUTPATIENT SERVICE COST CENTERS										
90.00	09000	CLINIC	5,754	1,391,615	1,397,369	1.506832	0.000000		90.00	
90.01	09001	WOUND CARE CENTER	1,893	217,903	219,796	0.537535	0.000000		90.01	
91.00	09100	EMERGENCY	2,509,863	3,973,579	6,483,442	0.510166	0.000000		91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,474,875	1,474,875	0.299309	0.000000		92.00	
OTHER REIMBURSABLE COST CENTERS										
99.10	09910	CORF	0	0	0				99.10	
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0				99.20	
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0				99.30	
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0				99.40	
SPECIAL PURPOSE COST CENTERS										
113.00	11300	INTEREST EXPENSE							113.00	
200.00		Subtotal (see instructions)	71,907,967	61,760,830	133,668,797				200.00	
201.00		Less Observation Beds							201.00	
202.00		Total (see instructions)	71,907,967	61,760,830	133,668,797				202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0115	Period: From 07/01/2018 To 06/30/2019	Worksheet C Part I Date/Time Prepared: 11/29/2019 2:06 pm
			Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio		
			11.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.950823		50.00
53.00	05300	ANESTHESIOLOGY	0.633948		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205236		54.00
54.01	03630	ULTRASOUND	0.119721		54.01
60.00	06000	LABORATORY	0.178591		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0.135158		65.00
66.00	06600	PHYSICAL THERAPY	2.024660		66.00
69.00	06900	ELECTROCARDIOLOGY	0.074478		69.00
69.01	03140	CARDIAC CATH LAB	0.593659		69.01
70.01	07001	SLEEP LAB	0.000000		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.361408		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.294093		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.223299		73.00
74.00	07400	RENAL DIALYSIS	0.455585		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.611360		75.00
75.01	03480	ONCOLOGY	0.351197		75.01
75.02	03340	GI LAB	0.117313		75.02
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1.506832		90.00
90.01	09001	WOUND CARE CENTER	0.537535		90.01
91.00	09100	EMERGENCY	0.510166		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.299309		92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY			99.40
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: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/29/2019 2:06 pm

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs		
						RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,039,279		14,039,279	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,023,262		1,023,262	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,434,384		2,434,384	0	0	50.00
53.00	05300	ANESTHESIOLOGY	697,584		697,584	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,626,937		2,626,937	0	0	54.00
54.01	03630	ULTRASOUND	277,658		277,658	0	0	54.01
60.00	06000	LABORATORY	4,560,565		4,560,565	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,075,744	0	1,075,744	0	0	65.00
66.00	06600	PHYSICAL THERAPY	321,601	0	321,601	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	178,556		178,556	0	0	69.00
69.01	03140	CARDIAC CATH LAB	116,816		116,816	0	0	69.01
70.01	07001	SLEEP LAB	0		0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,576,880		1,576,880	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	544,536		544,536	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,773,987		5,773,987	0	0	73.00
74.00	07400	RENAL DIALYSIS	202,169		202,169	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	905,413		905,413	0	0	75.00
75.01	03480	ONCOLOGY	851,494		851,494	0	0	75.01
75.02	03340	GI LAB	151,241		151,241	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,105,600		2,105,600	0	0	90.00
90.01	09001	WOUND CARE CENTER	118,148		118,148	0	0	90.01
91.00	09100	EMERGENCY	3,307,629		3,307,629	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	441,443		441,443	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0		0		0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0		0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0		0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0		0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	43,330,926	0	43,330,926	0	0	200.00
201.00		Less Observation Beds	441,443		441,443		0	201.00
202.00		Total (see instructions)	42,889,483	0	42,889,483	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/29/2019 2:06 pm

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0		0		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	54.00
54.01	03630	ULTRASOUND	0	0	0	0.000000	54.01
60.00	06000	LABORATORY	0	0	0	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
69.01	03140	CARDIAC CATH LAB	0	0	0	0.000000	69.01
70.01	07001	SLEEP LAB	0	0	0	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	75.00
75.01	03480	ONCOLOGY	0	0	0	0.000000	75.01
75.02	03340	GI LAB	0	0	0	0.000000	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
90.01	09001	WOUND CARE CENTER	0	0	0	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	0	0	0		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	0	0	0		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/29/2019 2:06 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	03630	ULTRASOUND	0.000000			54.01
60.00	06000	LABORATORY	0.000000			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
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
69.01	03140	CARDIAC CATH LAB	0.000000			69.01
70.01	07001	SLEEP LAB	0.000000			70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000			75.00
75.01	03480	ONCOLOGY	0.000000			75.01
75.02	03340	GI LAB	0.000000			75.02
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
90.01	09001	WOUND CARE CENTER	0.000000			90.01
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
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: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part I
Date/Time Prepared:
11/29/2019 2:06 pm

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		1,256,127	0	1,256,127	22,803	55.09	30.00
31.00	INTENSIVE CARE UNIT		84,314		84,314	161	523.69	31.00
200.00	Total (lines 30 through 199)		1,340,441		1,340,441	22,964		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		6,334	348,940				
31.00	INTENSIVE CARE UNIT		112	58,653				
200.00	Total (lines 30 through 199)		6,446	407,593	200.00			

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part II
Date/Time Prepared:
11/29/2019 2:06 pm

Cost Center Description			Title XVIII		Hospital	PPS		
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	192,198	2,560,292	0.075069	534,807	40,147	50.00
53.00	05300	ANESTHESIOLOGY	11,519	1,100,381	0.010468	170,412	1,784	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	229,262	12,799,600	0.017912	1,216,908	21,797	54.00
54.01	03630	ULTRASOUND	9,125	2,319,214	0.003935	201,978	795	54.01
60.00	06000	LABORATORY	172,004	25,536,316	0.006736	3,773,517	25,418	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	82,955	7,959,184	0.010423	2,930,091	30,540	65.00
66.00	06600	PHYSICAL THERAPY	63,155	158,842	0.397596	24,637	9,796	66.00
69.00	06900	ELECTROCARDIOLOGY	7,061	2,397,443	0.002945	413,616	1,218	69.00
69.01	03140	CARDIAC CATH LAB	37,452	196,773	0.190331	1,512	288	69.01
70.01	07001	SLEEP LAB	0	0	0.000000	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	144,439	4,363,158	0.033104	992,526	32,857	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	49,803	1,851,576	0.026898	496,589	13,357	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	62,020	25,857,621	0.002399	4,268,785	10,241	73.00
74.00	07400	RENAL DIALYSIS	2,846	443,757	0.006413	123,772	794	74.00
75.00	07500	ASC (NON-DISTINCT PART)	200,515	1,480,982	0.135393	0	0	75.00
75.01	03480	ONCOLOGY	114,468	2,424,550	0.047212	0	0	75.01
75.02	03340	GI LAB	44,089	1,289,213	0.034198	72,364	2,475	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	154,311	1,397,369	0.110430	5,502	608	90.00
90.01	09001	WOUND CARE CENTER	21,045	219,796	0.095748	0	0	90.01
91.00	09100	EMERGENCY	105,660	6,483,442	0.016297	606,803	9,889	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	39,497	1,474,875	0.026780	0	0	92.00
200.00		Total (lines 50 through 199)	1,743,424	102,314,384		15,833,819	202,004	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0115		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part III Date/Time Prepared: 11/29/2019 2:06 pm		
					Title XVIII		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	0	31.00	
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	22,803	0.00	6,334	0	30.00		
31.00	03100	INTENSIVE CARE UNIT		0	161	0.00	112	0	31.00		
200.00		Total (lines 30 through 199)		0	22,964		6,446	0	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
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0115

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

Worksheet D
Part IV
Date/Time Prepared:
11/29/2019 2:06 pm

Cost Center Description			Title XVIII		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRASOUND	0	0	0	0	0	54.01
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03140	CARDIAC CATH LAB	0	0	0	0	0	69.01
70.01	07001	SLEEP LAB	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03480	ONCOLOGY	0	0	0	0	0	75.01
75.02	03340	GI LAB	0	0	0	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE CENTER	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part IV
Date/Time Prepared:
11/29/2019 2:06 pm

Cost Center Description		Title XVIII			Hospital		PPS	
		All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	2,560,292	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,100,381	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,799,600	0.000000	54.00
54.01	03630	ULTRASOUND	0	0	0	2,319,214	0.000000	54.01
60.00	06000	LABORATORY	0	0	0	25,536,316	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,959,184	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	158,842	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,397,443	0.000000	69.00
69.01	03140	CARDIAC CATH LAB	0	0	0	196,773	0.000000	69.01
70.01	07001	SLEEP LAB	0	0	0	0	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,363,158	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,851,576	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	25,857,621	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	443,757	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	1,480,982	0.000000	75.00
75.01	03480	ONCOLOGY	0	0	0	2,424,550	0.000000	75.01
75.02	03340	GI LAB	0	0	0	1,289,213	0.000000	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	1,397,369	0.000000	90.00
90.01	09001	WOUND CARE CENTER	0	0	0	219,796	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	6,483,442	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,474,875	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	102,314,384		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part IV
Date/Time Prepared:
11/29/2019 2:06 pm

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	534,807	0	466,498	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	170,412	0	129,728	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,216,908	0	2,738,042	0	54.00
54.01	03630	ULTRASOUND	0.000000	201,978	0	257,994	0	54.01
60.00	06000	LABORATORY	0.000000	3,773,517	0	1,325,277	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	2,930,091	0	148,891	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	24,637	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	413,616	0	421,460	0	69.00
69.01	03140	CARDIAC CATH LAB	0.000000	1,512	0	52,169	0	69.01
70.01	07001	SLEEP LAB	0.000000	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	992,526	0	457,545	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	496,589	0	142,193	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	4,268,785	0	7,042,786	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	123,772	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	03480	ONCOLOGY	0.000000	0	0	102,998	0	75.01
75.02	03340	GI LAB	0.000000	72,364	0	170,050	0	75.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	5,502	0	771,935	0	90.00
90.01	09001	WOUND CARE CENTER	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	606,803	0	216,051	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	235,980	0	92.00
200.00		Total (lines 50 through 199)		15,833,819	0	14,679,597	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part V
Date/Time Prepared:
11/29/2019 2:06 pm

			Title XVIII		Hospital		PPS		
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.950823	466,498	0	0	443,557	50.00	
53.00	05300	ANESTHESIOLOGY	0.633948	129,728	0	0	82,241	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205236	2,738,042	0	0	561,945	54.00	
54.01	03630	ULTRASOUND	0.119721	257,994	0	0	30,887	54.01	
60.00	06000	LABORATORY	0.178591	1,325,277	0	0	236,683	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	0.135158	148,891	0	0	20,124	65.00	
66.00	06600	PHYSICAL THERAPY	2.024660	0	0	0	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	0.074478	421,460	0	0	31,389	69.00	
69.01	03140	CARDIAC CATH LAB	0.593659	52,169	0	0	30,971	69.01	
70.01	07001	SLEEP LAB	0.000000	0	0	0	0	70.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.361408	457,545	0	0	165,360	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.294093	142,193	0	0	41,818	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.223299	7,042,786	0	91,462	1,572,647	73.00	
74.00	07400	RENAL DIALYSIS	0.455585	0	0	0	0	74.00	
75.00	07500	ASC (NON-DISTINCT PART)	0.611360	0	0	0	0	75.00	
75.01	03480	ONCOLOGY	0.351197	102,998	0	0	36,173	75.01	
75.02	03340	GI LAB	0.117313	170,050	0	0	19,949	75.02	
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	1.506832	771,935	0	0	1,163,176	90.00	
90.01	09001	WOUND CARE CENTER	0.537535	0	0	0	0	90.01	
91.00	09100	EMERGENCY	0.510166	216,051	0	0	110,222	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.299309	235,980	0	0	70,631	92.00	
200.00		Subtotal (see instructions)		14,679,597	0	91,462	4,617,773	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		14,679,597	0	91,462	4,617,773	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part V
Date/Time Prepared:
11/29/2019 2:06 pm

			Title XVIII		Hospital	PPS
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03630	ULTRASOUND	0	0		54.01
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
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
69.01	03140	CARDIAC CATH LAB	0	0		69.01
70.01	07001	SLEEP LAB	0	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	20,423		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	03480	ONCOLOGY	0	0		75.01
75.02	03340	GI LAB	0	0		75.02
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CARE CENTER	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	20,423		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	20,423		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part I
Date/Time Prepared:
11/29/2019 2:06 pm

			Title XIX		Hospital	Cost	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,256,127	0	1,256,127	22,803	55.09	30.00
31.00	INTENSIVE CARE UNIT	84,314		84,314	161	523.69	31.00
200.00	Total (lines 30 through 199)	1,340,441		1,340,441	22,964		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	1,785	98,336				
31.00	INTENSIVE CARE UNIT	0	0				
200.00	Total (lines 30 through 199)	1,785	98,336				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part II
Date/Time Prepared:
11/29/2019 2:06 pm

Cost Center Description		Title XIX		Hospital		Cost	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	192,198	0	0.000000	151,788	0 50.00
53.00	05300	ANESTHESIOLOGY	11,519	0	0.000000	31,391	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	229,262	0	0.000000	304,725	0 54.00
54.01	03630	ULTRASOUND	9,125	0	0.000000	35,617	0 54.01
60.00	06000	LABORATORY	172,004	0	0.000000	774,488	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	82,955	0	0.000000	736,981	0 65.00
66.00	06600	PHYSICAL THERAPY	63,155	0	0.000000	11,911	0 66.00
69.00	06900	ELECTROCARDIOLOGY	7,061	0	0.000000	85,712	0 69.00
69.01	03140	CARDIAC CATH LAB	37,452	0	0.000000	7,936	0 69.01
70.01	07001	SLEEP LAB	0	0	0.000000	0	0 70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	144,439	0	0.000000	19,833	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	49,803	0	0.000000	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	62,020	0	0.000000	910,841	0 73.00
74.00	07400	RENAL DIALYSIS	2,846	0	0.000000	42,066	0 74.00
75.00	07500	ASC (NON-DISTINCT PART)	200,515	0	0.000000	18,539	0 75.00
75.01	03480	ONCOLOGY	114,468	0	0.000000	2,941	0 75.01
75.02	03340	GI LAB	44,089	0	0.000000	21,150	0 75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	154,311	0	0.000000	129	0 90.00
90.01	09001	WOUND CARE CENTER	21,045	0	0.000000	1,862	0 90.01
91.00	09100	EMERGENCY	105,660	0	0.000000	202,165	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	39,497	0	0.000000	0	0 92.00
200.00		Total (lines 50 through 199)	1,743,424	0		3,360,075	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0115		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part III Date/Time Prepared: 11/29/2019 2:06 pm		
					Title XIX		Hospital		Cost		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00		
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	200.00		
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	22,803	0.00	1,785	30.00			
31.00	03100	INTENSIVE CARE UNIT	0	0	161	0.00	0	31.00			
200.00		Total (lines 30 through 199)	0	0	22,964		1,785	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
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0115

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

Worksheet D
Part IV
Date/Time Prepared:
11/29/2019 2:06 pm

Cost Center Description			Title XIX		Hospital		Cost	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRASOUND	0	0	0	0	0	54.01
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03140	CARDIAC CATH LAB	0	0	0	0	0	69.01
70.01	07001	SLEEP LAB	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03480	ONCOLOGY	0	0	0	0	0	75.01
75.02	03340	GI LAB	0	0	0	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE CENTER	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description			Title XIX		Hospital	Cost	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)
			4.00	5.00	6.00	7.00	8.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0.000000
54.01	03630	ULTRASOUND	0	0	0	0	0.000000
60.00	06000	LABORATORY	0	0	0	0	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000
69.01	03140	CARDIAC CATH LAB	0	0	0	0	0.000000
70.01	07001	SLEEP LAB	0	0	0	0	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000
75.01	03480	ONCOLOGY	0	0	0	0	0.000000
75.02	03340	GI LAB	0	0	0	0	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0.000000
90.01	09001	WOUND CARE CENTER	0	0	0	0	0.000000
91.00	09100	EMERGENCY	0	0	0	0	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000
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: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part IV
Date/Time Prepared:
11/29/2019 2:06 pm

Cost Center Description		Title XIX			Hospital		Cost	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	151,788	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	31,391	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	304,725	0	0	0	54.00
54.01	03630	ULTRASOUND	0.000000	35,617	0	0	0	54.01
60.00	06000	LABORATORY	0.000000	774,488	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	736,981	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	11,911	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	85,712	0	0	0	69.00
69.01	03140	CARDIAC CATH LAB	0.000000	7,936	0	0	0	69.01
70.01	07001	SLEEP LAB	0.000000	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	19,833	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	910,841	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	42,066	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	18,539	0	0	0	75.00
75.01	03480	ONCOLOGY	0.000000	2,941	0	0	0	75.01
75.02	03340	GI LAB	0.000000	21,150	0	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	129	0	0	0	90.00
90.01	09001	WOUND CARE CENTER	0.000000	1,862	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	202,165	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		3,360,075	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0115	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/29/2019 2:06 pm	
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)			22,803	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			22,803	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)			22,086	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)			6,334	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)			14,039,279	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)			14,039,279	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)			14,039,279	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)			615.68	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			3,899,717	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)			3,899,717	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0115

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

Worksheet D-1

Date/Time Prepared:
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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	1,023,262	161	6,355.66	112	711,834	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,882,703	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					8,494,254	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)					407,593	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					202,004	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					609,597	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					7,884,657	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)					717	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					615.68	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					441,443	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0115

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

Worksheet D-1

Date/Time Prepared:
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		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	1,256,127	14,039,279	0.089472	441,443	39,497	90.00
91.00 Nursing School cost	0	14,039,279	0.000000	441,443	0	91.00
92.00 Allied health cost	0	14,039,279	0.000000	441,443	0	92.00
93.00 All other Medical Education	0	14,039,279	0.000000	441,443	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0115	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/29/2019 2:06 pm
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		22,803	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		22,803	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)		22,086	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,785	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)		14,039,279	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)		14,039,279	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)		14,039,279	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)		615.68	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,098,989	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,098,989	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0115

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

Worksheet D-1

Date/Time Prepared:
11/29/2019 2:06 pm

Cost Center Description		Title XIX		Hospital		Cost	
		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	1,023,262	161	6,355.66	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,098,989	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					717	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					615.68	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					441,443	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0115

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

Worksheet D-1

Date/Time Prepared:
11/29/2019 2:06 pm

Cost Center Description		Title XIX		Hospital		Cost
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,256,127	14,039,279	0.089472	441,443	39,497
91.00	Nursing School cost	0	14,039,279	0.000000	441,443	0
92.00	Allied health cost	0	14,039,279	0.000000	441,443	0
93.00	All other Medical Education	0	14,039,279	0.000000	441,443	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0115	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/29/2019 2:06 pm	
Cost Center Description		Title XVIII	Hospital	PPS	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		8,504,432	30.00
31.00	03100	INTENSIVE CARE UNIT		269,802	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.950823	534,807	508,507 50.00
53.00	05300	ANESTHESIOLOGY	0.633948	170,412	108,032 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205236	1,216,908	249,753 54.00
54.01	03630	ULTRASOUND	0.119721	201,978	24,181 54.01
60.00	06000	LABORATORY	0.178591	3,773,517	673,916 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0.135158	2,930,091	396,025 65.00
66.00	06600	PHYSICAL THERAPY	2.024660	24,637	49,882 66.00
69.00	06900	ELECTROCARDIOLOGY	0.074478	413,616	30,805 69.00
69.01	03140	CARDIAC CATH LAB	0.593659	1,512	898 69.01
70.01	07001	SLEEP LAB	0.000000	0	0 70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.361408	992,526	358,707 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.294093	496,589	146,043 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.223299	4,268,785	953,215 73.00
74.00	07400	RENAL DIALYSIS	0.455585	123,772	56,389 74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.611360	0	0 75.00
75.01	03480	ONCOLOGY	0.351197	0	0 75.01
75.02	03340	GI LAB	0.117313	72,364	8,489 75.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0 76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0 76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1.506832	5,502	8,291 90.00
90.01	09001	WOUND CARE CENTER	0.537535	0	0 90.01
91.00	09100	EMERGENCY	0.510166	606,803	309,570 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.299309	0	0 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		15,833,819	3,882,703 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net charges (line 200 minus line 201)		15,833,819	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0115	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/29/2019 2:06 pm	
Cost Center Description		Title XIX	Hospital	Cost	
		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		2,192,825	30.00
31.00	03100	INTENSIVE CARE UNIT		84,706	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000	151,788	0 50.00
53.00	05300	ANESTHESIOLOGY	0.000000	31,391	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	304,725	0 54.00
54.01	03630	ULTRASOUND	0.000000	35,617	0 54.01
60.00	06000	LABORATORY	0.000000	774,488	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	736,981	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	11,911	0 66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	85,712	0 69.00
69.01	03140	CARDIAC CATH LAB	0.000000	7,936	0 69.01
70.01	07001	SLEEP LAB	0.000000	0	0 70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	19,833	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	910,841	0 73.00
74.00	07400	RENAL DIALYSIS	0.000000	42,066	0 74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	18,539	0 75.00
75.01	03480	ONCOLOGY	0.000000	2,941	0 75.01
75.02	03340	GI LAB	0.000000	21,150	0 75.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0 76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0 76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	129	0 90.00
90.01	09001	WOUND CARE CENTER	0.000000	1,862	0 90.01
91.00	09100	EMERGENCY	0.000000	202,165	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,360,075	0 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net charges (line 200 minus line 201)		3,360,075	0 202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0115	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prepared: 11/29/2019 2:06 pm
		Title XVIII	Hospital	PPS
				1.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		2,223,719	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		6,671,156	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)		68,285	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		2,390,825	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		153.81	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)		22.44	30.00
31.00	Percentage of Medicaid patient days (see instructions)		52.65	31.00
32.00	Sum of lines 30 and 31		75.09	32.00
33.00	Allowable disproportionate share percentage (see instructions)		51.16	33.00
34.00	Disproportionate share adjustment (see instructions)		1,137,655	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0115	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prepared: 11/29/2019 2:06 pm
		Title XVIII	Hospital	PPS
			Prior to 10/1	On/After 10/1
			1.00	2.00
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		6,766,695,164	8,272,872,447
35.01	Factor 3 (see instructions)		0.000211815	0.000133182
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		1,433,288	1,101,798
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		361,267	824,084
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,185,351	
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	
			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
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.0000000	
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	
47.00	Subtotal (see instructions)		11,286,166	
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		11,286,166	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		850,548	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		12,136,714	59.00
60.00	Primary payer payments		6,906	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		12,129,808	61.00
62.00	Deductibles billed to program beneficiaries		828,596	62.00
63.00	Coinsurance billed to program beneficiaries		118,832	63.00
64.00	Allowable bad debts (see instructions)		917,920	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		596,648	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		457,765	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		11,779,028	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)		0	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)		-73,459	70.93
70.94	HRR adjustment amount (see instructions)		-26,369	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0115	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prepared: 11/29/2019 2:06 pm	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96	
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97	
70.98	Low Volume Payment-3		0	70.98	
70.99	HAC adjustment amount (see instructions)		89,809	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		11,589,391	71.00	
71.01	Sequestration adjustment (see instructions)		231,788	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
72.00	Interim payments		10,998,038	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)		359,565	74.00	
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		855,504	75.00	
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00	
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00	
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00	
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00	
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00	
95.00	Time value of money for operating expenses (see instructions)		0	95.00	
96.00	Time value of money for capital related expenses (see instructions)		0	96.00	
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	100.00	
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00	
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00	
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00	
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00	
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00	
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00	
202.00	Medicare discharges (see instructions)			202.00	
203.00	Case-mix adjustment factor (see instructions)			203.00	
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount			204.00	
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00	
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00	
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00	
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00	
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00	
210.00	Reserved for future use			210.00	
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00	
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00	
213.00	Low-volume adjustment (see instructions)			213.00	
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00	

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/29/2019 2:06 pm

		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	2,223,719	2,223,719		2,223,719	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	6,671,156		6,671,156	6,671,156	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	68,285	17,071	51,214	68,285	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	2,390,825	597,706	1,793,119	2,390,825	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	0.5116	0.5116	0.5116		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	1,137,655	284,414	853,241	1,137,655	11.00
11.01	Uncompensated care payments	36.00	1,185,351	361,267	824,084	1,185,351	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	11,286,166	2,886,471	8,399,695	11,286,166	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	11,286,166	2,886,471	8,399,695	11,286,166	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	850,548	212,637	637,911	850,548	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			3,099,108	9,037,606	12,136,714	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/29/2019 2:06 pm

		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	723,820	180,955	542,865	723,820	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	7,804	1,951	5,853	7,804	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	0.1643	0.1643	0.1643		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	118,924	29,731	89,193	118,924	25.00
26.00	Total prospective capital payments (see instructions)	12.00	850,548	212,637	637,911	850,548	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	-73,459	-49,489	-23,970	-73,459	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	-26,369	6,321	-32,690	-26,369	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	89,809	89,809	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0115	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 11/29/2019 2:06 pm
		Title XVIII	Hospital	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		20,423	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		4,617,773	2.00
3.00	OPPS payments		3,614,869	3.00
4.00	Outlier payment (see instructions)		2,285	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.820	5.00
6.00	Line 2 times line 5		3,786,574	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		95.53	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		20,423	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		91,462	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)		91,462	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)		91,462	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		71,039	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		20,423	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)		3,617,154	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)		742,254	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)		2,895,323	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)		2,895,323	30.00
31.00	Primary payer payments		1,421	31.00
32.00	Subtotal (line 30 minus line 31)		2,893,902	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)		425,279	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		276,431	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		359,436	36.00
37.00	Subtotal (see instructions)		3,170,333	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,170,333	40.00
40.01	Sequestration adjustment (see instructions)		63,407	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		3,129,009	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-22,083	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: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet E-1
Part I
Date/Time Prepared:
11/29/2019 2:06 pm

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		10,670,910		3,133,864	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
3.10		06/26/2019	327,128		0	3.10
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0	06/26/2019	4,855	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)		327,128		-4,855	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)		10,998,038		3,129,009	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		359,565		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		22,083	6.02
7.00	Total Medicare program liability (see instructions)		11,357,603		3,106,926	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: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet E-1
Part II
Date/Time Prepared:
11/29/2019 2:06 pm

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

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

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet E-3
Part VII
Date/Time Prepared:
11/29/2019 2:06 pm

		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		1,098,989		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		1,098,989	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		1,098,989	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		2,277,531		8.00
9.00	Ancillary service charges		3,360,075	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		5,637,606	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		5,637,606	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		4,538,617	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		1,098,989	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		1,098,989	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		1,098,989	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		1,098,989	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		1,098,989	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		1,098,989	0	40.00
41.00	Interim payments		1,098,989	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 14-0115

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

Worksheet G

Date/Time Prepared:
11/29/2019 2:06 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	4,199,938	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	10,986,488	0	0	0	4.00
5.00	Other receivable	794,009	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,636,540	0	0	0	6.00
7.00	Inventory	1,408,835	0	0	0	7.00
8.00	Prepaid expenses	558,346	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)	13,311,076	0	0	0	11.00
FIXED ASSETS						
12.00	Land	14,137,215	0	0	0	12.00
13.00	Land improvements	1,628,948	0	0	0	13.00
14.00	Accumulated depreciation	-1,503,973	0	0	0	14.00
15.00	Buildings	65,328,438	0	0	0	15.00
16.00	Accumulated depreciation	-41,508,009	0	0	0	16.00
17.00	Leasehold improvements	44,885	0	0	0	17.00
18.00	Accumulated depreciation	-26,088	0	0	0	18.00
19.00	Fixed equipment	14,524,552	0	0	0	19.00
20.00	Accumulated depreciation	-6,237,604	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	27,128,876	0	0	0	23.00
24.00	Accumulated depreciation	-24,913,872	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)	48,603,368	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	314,566,822	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	4,223,630	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	318,790,452	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	380,704,896	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,303,138	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,223,360	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	6,633,746	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	10,160,244	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	12,170,472	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	12,170,472	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	22,330,716	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	358,374,180				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)	358,374,180	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	380,704,896	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0115

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

Worksheet G-1

Date/Time Prepared:
11/29/2019 2:06 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		282,057,079		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		19,982,615				2.00
3.00	Total (sum of line 1 and line 2)		302,039,694		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)		302,039,694		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)		302,039,694		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: 14-0115

Period:
From 07/01/2018
To 06/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
11/29/2019 2:06 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	30,419,794		30,419,794	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)	30,419,794		30,419,794	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	944,995		944,995	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	944,995		944,995	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	31,364,789		31,364,789	17.00
18.00	Ancillary services	40,509,461		40,509,461	18.00
19.00	Outpatient services	0	69,223,023	69,223,023	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
24.10	CORF	0	0	0	24.10
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
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)	71,874,250	69,223,023	141,097,273	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		58,386,471		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)		58,386,471		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0115

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

Worksheet G-3

Date/Time Prepared:
11/29/2019 2:06 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	141,097,273	1.00
2.00	Less contractual allowances and discounts on patients' accounts	93,112,010	2.00
3.00	Net patient revenues (line 1 minus line 2)	47,985,263	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	58,386,471	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-10,401,208	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	8,331,694	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	17	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	89,237	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	2,900	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	1,148,555	22.00
23.00	Governmental appropriations	0	23.00
24.00	UNREALIZED GAIN ON INVESTMENT	4,239,172	24.00
24.01	MEANINGFUL USE REVENUE INCL ACCRUAL	0	24.01
24.02	GAIN ON INVESTMENT	4,115,962	24.02
24.03	MISC OPERATING REVENUE	345,015	24.03
24.04	PROVIDER TAX REV	12,763,385	24.04
24.05	NON OPERATING EXPENSES	-652,114	24.05
25.00	Total other income (sum of lines 6-24)	30,383,823	25.00
26.00	Total (line 5 plus line 25)	19,982,615	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)	19,982,615	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0115	Period: From 07/01/2018 To 06/30/2019	Worksheet L Parts I-III Date/Time Prepared: 11/29/2019 2:06 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		723,820	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		7,804	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)		60.95	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)		22.44	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		52.65	8.00
9.00	Sum of lines 7 and 8		75.09	9.00
10.00	Allowable disproportionate share percentage (see instructions)		16.43	10.00
11.00	Disproportionate share adjustment (see instructions)		118,924	11.00
12.00	Total prospective capital payments (see instructions)		850,548	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