

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

OMB NO. 0938-0050
EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION
AND SETTLEMENT SUMMARY

Provider CCN: 14-0143

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

Worksheet S
Parts I-III
Date/Time Prepared:
2/26/2020 11:17 am

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 2/26/2020	Time: 11:17 am
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status	6. Date Received:	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. ☒ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter
	(3) Settled with Audit	9. ☒ Final Report for this Provider CCN	number of times reopened = 0-9.
	(4) Reopened		
	(5) Amended		

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. MARGARET'S HOSPITAL (14-0143) for the cost reporting period beginning 10/01/2018 and ending 09/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

☐ I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed)

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	164,325	-4,111	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
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
200.00	Total	0	164,325	-4,111	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: 14-0143		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/26/2020 11:17 am	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 600 EAST FIRST ST			PO Box:				1.00		
2.00	City: SPRING VALLEY			State: IL		Zip Code: 61362		County: BUREAU		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	XIX
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		ST. MARGARET'S HOSPITAL	140143	99914	1	07/01/1966	N	P	P
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		ST. MARGARET'S HOSPITAL	14U143	99914		06/23/2003	N	P	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice		ST. MARGARET'S HOSPITAL	141595	99914		07/07/1998			
15.00	Hospital-Based Health Clinic - RHC									
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						10/01/2018	09/30/2019		20.00
21.00	Type of Control (see instructions)						1			21.00
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	N			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N			23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
				1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			714	0	0	0	182	0	24.00

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				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
				1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			0	0	0	0	0	25.00	
							Urban/Rural S	Date of Geogr		
							1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						2		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						2		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0		35.00	
							Beginning:	Ending:		
							1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.						1		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.						10/01/2018	09/30/2019	38.00	
							Y/N	Y/N		
							1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)						N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)						N	Y	40.00	
							V	XVIII	XIX	
							1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital										
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)						N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.						N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.						N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.						N	N	N	48.00
Teaching Hospitals										
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.						N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.									57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.						N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.						N			59.00
					NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
					1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)				N				60.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part I
Date/Time Prepared:
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	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00	2.00	3.00	4.00		
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
			1.00	2.00	3.00		
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				75.00	

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			1.00	2.00	3.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00

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		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N		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
						1.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N					111.00
						1.00	
						2.00	
						3.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N					116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y					117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1					118.00
		Premiums		Losses		Insurance	
		1.00		2.00		3.00	
118.01	List amounts of malpractice premiums and paid losses:	535,624		0		0	
						1.00	
						2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N					118.02
119.00	DO NOT USE THIS LINE						119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N				Y	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							

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Provider CCN: 14-0143		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/26/2020 11:17 am	
			1.00		2.00			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)			Y		35H002		140.00
			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: SISTERS MARY OF THE PRESENTATION HC		Contractor's Name: NORIDIAN ADMIN SVC		Contractor's Number: 03001		141.00	
142.00	Street: 1202 PAGE DR SW PO BOX 10007		PO Box:				142.00	
143.00	City: FARGO		State: ND		Zip Code: 58106-0007		143.00	
			1.00		2.00			
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.			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		2.00			
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	
			1.00		2.00		3.00	
			Title XIX		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	
156.00	Subprovider - IPF		N		N		N	
157.00	Subprovider - IRF		N		N		N	
158.00	SUBPROVIDER		N		N		N	
159.00	SNF		N		N		N	
160.00	HOME HEALTH AGENCY		N		N		N	
161.00	CMHC		N		N		N	
			1.00		2.00		3.00	
			Title XIX		4.00			
165.00	Multicampus 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	
			0		1.00		2.00	
			Zip Code		CBSA		FTE/Campus	
			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				166.00
			1.00		2.00		3.00	
			Title XIX		4.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y				167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			0.00				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)			0.00				168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.00				169.00
			Beginning		Ending			
			1.00		2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0143	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part I Date/Time Prepared: 2/26/2020 11:17 am
			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		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0143	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part II Date/Time Prepared: 2/26/2020 11:17 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	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.	Y		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		16.00
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	01/09/2020	17.00
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.	Y		18.00
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		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part II
Date/Time Prepared:
2/26/2020 11:17 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	PIP PYMTS WERE ENTERED AS PAYMENT.	Y	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.	DON	TROGLIO		41.00
42.00	Enter the employer/company name of the cost report preparer.	ST. MARGARET'S HOSPITAL			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	815-664-1328	DTROGLIO@ABOUTSMG.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part II
Date/Time Prepared:
2/26/2020 11:17 am

		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR OF ACCOUNTING		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: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
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Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					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	38	13,870	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)		38	13,870	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	6	2,190	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		44	16,060	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	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		44				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: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/26/2020 11:17 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents	
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll
		6.00	7.00	8.00	9.00	10.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,113	501	5,289		1.00
2.00	HMO and other (see instructions)	952	182			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	2		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)	3,113	501	5,291		7.00
8.00	INTENSIVE CARE UNIT	431	13	752		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		197	577		13.00
14.00	Total (see instructions)	3,544	711	6,620	0.00	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	0	0	0	0.00	24.00
24.10	HOSPICE (non-distinct part)			0		24.10
25.00	CMHC - CMHC					25.00
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	593.91
28.00	Observation Bed Days		322	2,197		28.00
29.00	Ambulance Trips	446				29.00
30.00	Employee discount days (see instruction)			24		30.00
31.00	Employee discount days - IRF			0		31.00
32.00	Labor & delivery days (see instructions)	0	3	115		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: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/26/2020 11:17 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	923	255	1,830	1.00
2.00 HMO and other (see instructions)			226	83		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	923	255	1,830	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	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					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: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part II
Date/Time Prepared:
2/26/2020 11:17 am

	Wkst. A Line Number	Amount Reported	Reclassificat ion 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	38,285,423	736,646	39,022,069	1,239,841.03	31.47 1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00 2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00 3.00
4.00	Physician-Part A - Administrative		0	8,668	8,668	54.00	160.52 4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00 4.01
5.00	Physician and Non Physician-Part B		7,825,949	764,418	8,590,367	49,850.20	172.32 5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00 6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00 7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00 7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00 8.00
9.00	SNF	44.00	0	0	0	0.00	0.00 9.00
10.00	Excluded area salaries (see instructions)		1,265,326	124,617	1,389,943	54,252.92	25.62 10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		616,745	0	616,745	8,793.50	70.14 11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00 12.00
13.00	Contract labor: Physician-Part A - Administrative		690,129	0	690,129	3,763.10	183.39 13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00 14.00
14.01	Home office salaries		1,325,662	0	1,325,662	8,265.00	160.39 14.01
14.02	Related organization salaries		0	0	0	0.00	0.00 14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00 15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		7,029,687	0	7,029,687		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		286,487	0	286,487		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		296,344	0	296,344		
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)		302,332	0	302,332		
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		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part II
Date/Time Prepared:
2/26/2020 11:17 am

	Wkst. A Line Number	Amount Reported	Reclassificat ion 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	
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	216,177	0	216,177	7,837.25	27.58
27.00	Administrative & General	5.00	3,365,721	-124,617	3,241,104	133,376.66	24.30
28.00	Administrative & General under contract (see inst.)		1,162,294	0	1,162,294	4,537.90	256.13
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	570,006	0	570,006	24,697.65	23.08
31.00	Laundry & Linen Service	8.00	0	43,398	43,398	2,800.34	15.50
32.00	Housekeeping	9.00	571,276	-43,398	527,878	38,530.20	13.70
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	816,002	-623,752	192,250	12,013.22	16.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	623,752	623,752	38,976.68	16.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	1,189,729	0	1,189,729	29,363.35	40.52
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00
41.00	Medical Records & Medical Records Library	16.00	1,450,069	0	1,450,069	52,184.48	27.79
42.00	Social Service	17.00	0	0	0	0.00	0.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part III
Date/Time Prepared:
2/26/2020 11:17 am

	Worksheet A Line Number	Amount Reported	Reclassificat ion 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)	31,621,768	-27,772	31,593,996	1,194,528.73	26.45	1.00
2.00	Excluded area salaries (see instructions)	1,265,326	124,617	1,389,943	54,252.92	25.62	2.00
3.00	Subtotal salaries (line 1 minus line 2)	30,356,442	-152,389	30,204,053	1,140,275.81	26.49	3.00
4.00	Subtotal other wages & related costs (see inst.)	2,632,536	0	2,632,536	20,821.60	126.43	4.00
5.00	Subtotal wage-related costs (see inst.)	7,332,019	0	7,332,019	0.00	24.27	5.00
6.00	Total (sum of lines 3 thru 5)	40,320,997	-152,389	40,168,608	1,161,097.41	34.60	6.00
7.00	Total overhead cost (see instructions)	9,341,274	-124,617	9,216,657	344,317.73	26.77	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part IV
Date/Time Prepared:
2/26/2020 11:17 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	867,959	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)	3,388,646	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	225,496	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	38,507	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	3,582	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	272,668	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	267,305	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	1,982,869	17.00
18.00	Medicare Taxes - Employers Portion Only	551,117	18.00
19.00	Unemployment Insurance	1,408	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	12,962	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	7,612,519	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part V
Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	616,745	7,612,519	1.00
2.00	Hospital	616,745	7,612,519	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	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0143

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

Worksheet S-7

Date/Time Prepared:
2/26/2020 11:17 am

		1.00	2.00	
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.	Y		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.	Y	06/23/2003	2.00
		Group	SNF Days	Swing Bed SNF Days
		1.00	2.00	3.00
		Total (sum of col. 2 + 3)		
		1.00	2.00	3.00
3.00		RUX	0	0
4.00		RUL	0	0
5.00		RVX	0	0
6.00		RVL	0	0
7.00		RHX	0	0
8.00		RHL	0	0
9.00		RMX	0	0
10.00		RML	0	0
11.00		RLX	0	0
12.00		RUC	0	0
13.00		RUB	0	0
14.00		RUA	0	0
15.00		RVC	0	0
16.00		RVB	0	0
17.00		RVA	0	0
18.00		RHC	0	0
19.00		RHB	0	0
20.00		RHA	0	0
21.00		RMC	0	0
22.00		RMB	0	0
23.00		RMA	0	0
24.00		RLB	0	0
25.00		RLA	0	0
26.00		ES3	0	0
27.00		ES2	0	0
28.00		ES1	0	0
29.00		HE2	0	0
30.00		HE1	0	0
31.00		HD2	0	0
32.00		HD1	0	0
33.00		HC2	0	0
34.00		HC1	0	0
35.00		HB2	0	0
36.00		HB1	0	0
37.00		LE2	0	0
38.00		LE1	0	0
39.00		LD2	0	0
40.00		LD1	0	0
41.00		LC2	0	0
42.00		LC1	0	0
43.00		LB2	0	0
44.00		LB1	0	0
45.00		CE2	0	0
46.00		CE1	0	0
47.00		CD2	0	0
48.00		CD1	0	0
49.00		CC2	0	0
50.00		CC1	0	0
51.00		CB2	0	0
52.00		CB1	0	0
53.00		CA2	0	0
54.00		CA1	0	0
55.00		SE3	0	0
56.00		SE2	0	0
57.00		SE1	0	0
58.00		SSC	0	0
59.00		SSB	0	0
60.00		SSA	0	0
61.00		IB2	0	0
62.00		IB1	0	0
63.00		IA2	0	0
64.00		IA1	0	0
65.00		BB2	0	0
66.00		BB1	0	0
67.00		BA2	0	0
68.00		BA1	0	0

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0143

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

Worksheet S-7

Date/Time Prepared:
2/26/2020 11:17 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	0	0	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
SNF SERVICES						
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).			99914	99914	201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing			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-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 14-0143

Period:

Worksheet S-9

Hospice CCN: 14-1595

From 10/01/2018
To 09/30/2019PARTS I THROUGH IV
Date/Time Prepared:
2/26/2020 11:17 am

		Hospice I					
		Unduplicated Days					
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)
		1.00	2.00	3.00	4.00	5.00	6.00
PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
1.00	Hospice Continuous Home Care						1.00
2.00	Hospice Routine Home Care						2.00
3.00	Hospice Inpatient Respite Care						3.00
4.00	Hospice General Inpatient Care						4.00
5.00	Total Hospice Days						5.00
Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
6.00	Number of patients receiving hospice care						6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare						7.00
8.00	Average Length of Stay (line 5 / line 6)						8.00
9.00	Unduplicated census count						9.00

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	6,475	0	0	6,475	11.00
12.00	Hospice Inpatient Respite Care	17	0	0	17	12.00
13.00	Hospice General Inpatient Care	111	0	0	111	13.00
14.00	Total Hospice Days	6,603	0	0	6,603	14.00
PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0143	Period: From 10/01/2018 To 09/30/2019	Worksheet S-10 Date/Time Prepared: 2/26/2020 11:17 am
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.320709 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	2,303,656		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	29,281,441		6.00
7.00	Medicaid cost (line 1 times line 6)	9,390,822		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	7,087,166		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	2,500		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	7,087,166		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)	1,957,185	1,000,939	2,958,124 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	627,687	1,000,939	1,628,626 21.00
22.00	Payments received from patients for amounts previously written off as charity care	4,155	93,631	97,786 22.00
23.00	Cost of charity care (line 21 minus line 22)	623,532	907,308	1,530,840 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)	2,489,302		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	260,554		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	400,853		27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,088,449		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	810,083		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,340,923		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	9,428,089		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0143

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

Worksheet A

Date/Time Prepared:

2/26/2020 11:17 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (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	NEW CAP REL COSTS-BLDG & FIXT		3,522,221	3,522,221	-284,017	3,238,204	1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT		450	450	0	450	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2,924,691	2,924,691	149,163	3,073,854	2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	216,177	7,763,854	7,980,031	0	7,980,031	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,365,721	7,558,351	10,924,072	-155,604	10,768,468	5.00
7.00	00700	OPERATION OF PLANT	570,006	1,644,698	2,214,704	0	2,214,704	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	154,608	154,608	43,398	198,006	8.00
9.00	00900	HOUSEKEEPING	571,276	230,851	802,127	-43,398	758,729	9.00
10.00	01000	DIETARY	816,002	443,090	1,259,092	-962,455	296,637	10.00
11.00	01100	CAFETERIA	0	0	0	962,455	962,455	11.00
13.00	01300	NURSING ADMINISTRATION	1,189,729	93,689	1,283,418	0	1,283,418	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,450,069	371,188	1,821,257	0	1,821,257	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,135,774	1,386,269	4,522,043	-95,821	4,426,222	30.00
31.00	03100	INTENSIVE CARE UNIT	787,831	40,403	828,234	0	828,234	31.00
43.00	04300	NURSERY	56,292	147,920	204,212	0	204,212	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,185,148	4,579,683	6,764,831	0	6,764,831	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	281,691	59,955	341,646	95,821	437,467	52.00
53.00	05300	ANESTHESIOLOGY	0	1,929,160	1,929,160	0	1,929,160	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	921,902	1,226,684	2,148,586	0	2,148,586	54.00
54.01	05402	NUCLEAR MEDICINE	129,596	437,455	567,051	0	567,051	54.01
57.00	05700	CT SCAN	141,931	251,984	393,915	0	393,915	57.00
60.00	06000	LABORATORY	1,029,038	2,130,416	3,159,454	0	3,159,454	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	210,273	210,273	0	210,273	63.00
65.00	06500	RESPIRATORY THERAPY	403,332	66,803	470,135	0	470,135	65.00
66.00	06600	PHYSICAL THERAPY	1,374,032	128,000	1,502,032	0	1,502,032	66.00
67.00	06700	OCCUPATIONAL THERAPY	168,315	4,944	173,259	0	173,259	67.00
68.00	06800	SPEECH PATHOLOGY	70,738	50,536	121,274	0	121,274	68.00
69.00	06900	ELECTROCARDIOLOGY	106,288	169,234	275,522	0	275,522	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	64,691	68,309	133,000	0	133,000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	40,017	245,561	285,578	4,804	290,382	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,357,702	2,357,702	0	2,357,702	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	798,773	2,270,617	3,069,390	-4,804	3,064,586	73.00
76.00	03020	SONOGRAPHY	192,423	359,640	552,063	0	552,063	76.00
76.01	03040	AUDIOLOGY	0	0	0	252,381	252,381	76.01
76.02	03160	CARDIAC REHAB	194,704	21,437	216,141	0	216,141	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	15,747,382	3,983,550	19,730,932	1,032,681	20,763,613	90.00
91.00	09100	EMERGENCY	1,011,219	1,674,226	2,685,445	0	2,685,445	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	762,146	762,146	0	762,146	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	1,161,059	1,161,059	-1,161,059	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
116.00	11600	HOSPICE	562,169	823,365	1,385,534	0	1,385,534	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,582,266	51,255,022	88,837,288	-166,455	88,670,833	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	CONGREGATE LIVING	36,387	6,486	42,873	0	42,873	194.00
194.01	07951	OTHER	0	0	0	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	47,874	8,936	56,810	0	56,810	194.03
194.04	07954	RENTAL AREA/PPOS	0	0	0	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	1,745	1,745	0	1,745	194.05
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	247,647	378,108	625,755	0	625,755	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18

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RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0143

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

Worksheet A

Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20	07970	PARATRANSIT	0	0	0	166,455	166,455	194.20
194.21	07971	OCCUPATIONAL HEALTH	229,891	29,399	259,290	0	259,290	194.21
194.24	07974	SURGICAL ASSOCIATES	0	221	221	0	221	194.24
194.27	07977	MIDTOWN	0	0	0	0	0	194.27
194.28	07978	PAIN CLINIC	141,358	65,249	206,607	0	206,607	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
194.31	07981	CFH	0	0	0	0	0	194.31
194.32	07982	PFS	0	0	0	0	0	194.32
200.00		TOTAL (SUM OF LINES 118 through 199)	38,285,423	51,745,166	90,030,589	0	90,030,589	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0143

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

Worksheet A

Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-55,644	3,182,560	1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT	0	450	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-1,044	3,072,810	2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP	49	49	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,427,358	6,552,673	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-85,524	10,682,944	5.00
7.00	00700	OPERATION OF PLANT	-1,800	2,212,904	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	198,006	8.00
9.00	00900	HOUSEKEEPING	0	758,729	9.00
10.00	01000	DIETARY	0	296,637	10.00
11.00	01100	CAFETERIA	-237,135	725,320	11.00
13.00	01300	NURSING ADMINISTRATION	-4,735	1,278,683	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,404	1,819,853	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-865,194	3,561,028	30.00
31.00	03100	INTENSIVE CARE UNIT	-10,200	818,034	31.00
43.00	04300	NURSERY	-127,500	76,712	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	6,764,831	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	437,467	52.00
53.00	05300	ANESTHESIOLOGY	-1,723,909	205,251	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,148,586	54.00
54.01	05402	NUCLEAR MEDICINE	0	567,051	54.01
57.00	05700	CT SCAN	0	393,915	57.00
60.00	06000	LABORATORY	0	3,159,454	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	210,273	63.00
65.00	06500	RESPIRATORY THERAPY	0	470,135	65.00
66.00	06600	PHYSICAL THERAPY	-1,384	1,500,648	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	173,259	67.00
68.00	06800	SPEECH PATHOLOGY	0	121,274	68.00
69.00	06900	ELECTROCARDIOLOGY	-20,800	254,722	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	133,000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	290,382	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,357,702	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-263,521	2,801,065	73.00
76.00	03020	SONOGRAPHY	0	552,063	76.00
76.01	03040	AUDIOLOGY	0	252,381	76.01
76.02	03160	CARDIAC REHAB	0	216,141	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	-7,304,019	13,459,594	90.00
91.00	09100	EMERGENCY	-955,157	1,730,288	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	762,146	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	114.00
116.00	11600	HOSPICE	0	1,385,534	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-13,086,279	75,584,554	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	CONGREGATE LIVING	0	42,873	194.00
194.01	07951	OTHER	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	194.02
194.03	07953	MANAGED CARE	0	56,810	194.03
194.04	07954	RENTAL AREA/PPOS	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	1,745	194.05
194.08	07958	ENT	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	625,755	194.09
194.10	07960	PERU MALL	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	194.13
194.14	07964	HENRY	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	194.19

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RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0143

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

Worksheet A

Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
194.20	07970 PARATRANSIT	0	166,455	194.20
194.21	07971 OCCUPATIONAL HEALTH	0	259,290	194.21
194.24	07974 SURGICAL ASSOCIATES	0	221	194.24
194.27	07977 MIDTOWN	0	0	194.27
194.28	07978 PAIN CLINIC	0	206,607	194.28
194.30	07980 WHC-PTON	0	0	194.30
194.31	07981 CFH	0	0	194.31
194.32	07982 PFS	0	0	194.32
200.00	TOTAL (SUM OF LINES 118 through 199)	-13,086,279	76,944,310	200.00

RECLASSIFICATIONS

Provider CCN: 14-0143

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

Worksheet A-6

Date/Time Prepared:
2/26/2020 11:17 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
1.00	A - IV COSTS FROM PHARMACY				1.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	4,804	
	TOTALS		0	4,804	
1.00	B - DIETARY RECLASS				1.00
	CAFETERIA	11.00	623,752	338,703	
	TOTALS		623,752	338,703	
1.00	C - LAUNDRY SALARIES				1.00
	LAUNDRY & LINEN SERVICE	8.00	43,398	0	
	TOTALS		43,398	0	
1.00 2.00 3.00	D - DEPRECIATION FOR OFF CAMPUS CLINICS				1.00 2.00 3.00
	CLINIC	90.00	0	1,285,062	
		0.00	0	0	
		0.00	0	0	
	TOTALS		0	1,285,062	
1.00	E - AUDIOLOGY COSTS				1.00
	AUDIOLOGY	76.01	0	252,381	
	TOTALS		0	252,381	
1.00 2.00 3.00	F - INTEREST EXPENSE ON EQUIPMENT				1.00 2.00 3.00
	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	149,163	
	ADMINISTRATIVE & GENERAL	5.00	0	10,851	
	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,001,045	
	TOTALS		0	1,161,059	
1.00	G - PARATRANSIT COSTS				1.00
	PARATRANSIT	194.20	124,617	41,838	
	TOTALS		124,617	41,838	
1.00	H - LABOR AND DELIVERY SALARIES				1.00
	DELIVERY ROOM & LABOR ROOM	52.00	95,821	0	
	TOTALS		95,821	0	
1.00	I - TO RECLASS EMPLOYED HOSPITALIST				1.00
	ADULTS & PEDIATRICS	30.00	736,646	0	
	TOTALS		736,646	0	
500.00	Grand Total: Increases		1,624,234	3,083,847	500.00

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - IV COSTS FROM PHARMACY						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,804	0		1.00
	TOTALS		0	4,804			
	B - DIETARY RECLASS						
1.00	DIETARY	10.00	623,752	338,703	0		1.00
	TOTALS		623,752	338,703			
	C - LAUNDRY SALARIES						
1.00	HOUSEKEEPING	9.00	43,398	0	0		1.00
	TOTALS		43,398	0			
	D - DEPRECIATION FOR OFF CAMPUS CLINICS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,285,062	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	9		3.00
	TOTALS		0	1,285,062			
	E - AUDIOLOGY COSTS						
1.00	CLINIC	90.00	0	252,381	0		1.00
	TOTALS		0	252,381			
	F - INTEREST EXPENSE ON EQUIPMENT						
1.00	INTEREST EXPENSE	113.00	0	1,161,059	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	11		3.00
	TOTALS		0	1,161,059			
	G - PARATRANSIT COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	124,617	41,838	0		1.00
	TOTALS		124,617	41,838			
	H - LABOR AND DELIVERY SALARIES						
1.00	ADULTS & PEDIATRICS	30.00	95,821	0	0		1.00
	TOTALS		95,821	0			
	I - TO RECLASS EMPLOYED HOSPITALIST						
1.00	ADULTS & PEDIATRICS	30.00	0	736,646	0		1.00
	TOTALS		0	736,646			
500.00	Grand Total: Decreases		887,588	3,820,493			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part I
Date/Time Prepared:
2/26/2020 11:17 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,841,557	0	0	0	0	1.00
2.00	Land Improvements	3,217,398	89,148	0	89,148	0	2.00
3.00	Buildings and Fixtures	71,374,149	3,297,925	0	3,297,925	879,072	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	31,955,484	1,355,163	0	1,355,163	253,506	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	109,388,588	4,742,236	0	4,742,236	1,132,578	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	109,388,588	4,742,236	0	4,742,236	1,132,578	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,841,557	0				1.00
2.00	Land Improvements	3,306,546	0				2.00
3.00	Buildings and Fixtures	73,793,002	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	33,057,141	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	112,998,246	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	112,998,246	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part II
Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	3,522,221	0	0	0	0	1.00
1.01	OLD CAP REL COSTS-BLDG & FIXT	450	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2,924,691	0	0	0	0	2.00
2.01	OLD CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	6,447,362	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1)				
		Capital-Relat	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	3,522,221				1.00
1.01	OLD CAP REL COSTS-BLDG & FIXT	0	450				1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	2,924,691				2.00
2.01	OLD CAP REL COSTS-MVBLE EQUIP	0	0				2.01
3.00	Total (sum of lines 1-2)	0	6,447,362				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part III
Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
		1.00	2.00	3.00	4.00	5.00		
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	78,857,810	0	78,857,810	0.697867	0	1.00	
1.01	OLD CAP REL COSTS-BLDG & FIXT	1,083,295	0	1,083,295	0.009587	0	1.01	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	33,046,462	0	33,046,462	0.292451	0	2.00	
2.01	OLD CAP REL COSTS-MVBLE EQUIP	10,679	0	10,679	0.000095	0	2.01	
3.00	Total (sum of lines 1-2)	112,998,246	0	112,998,246	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	2,237,159	0	1.00	
1.01	OLD CAP REL COSTS-BLDG & FIXT	0	0	0	450	0	1.01	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	2,923,647	0	2.00	
2.01	OLD CAP REL COSTS-MVBLE EQUIP	0	0	0	49	0	2.01	
3.00	Total (sum of lines 1-2)	0	0	0	5,161,305	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	NEW CAP REL COSTS-BLDG & FIXT	945,401	0	0	0	3,182,560	1.00	
1.01	OLD CAP REL COSTS-BLDG & FIXT	0	0	0	0	450	1.01	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	149,163	0	0	0	3,072,810	2.00	
2.01	OLD CAP REL COSTS-MVBLE EQUIP	0	0	0	0	49	2.01	
3.00	Total (sum of lines 1-2)	1,094,564	0	0	0	6,255,869	3.00	

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0143

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

Worksheet A-8

Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-55,644	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - OLD CAP REL COSTS-BLDG & FIXT (chapter 2)		0	OLD CAP REL COSTS-BLDG & FIXT	1.01	0	1.01
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - OLD CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	OLD CAP REL COSTS-MVBLE EQUIP	2.01	0	2.01
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)	B	-1,194	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-1,800	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-11,241,214			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	165,513			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-237,135	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-263,521	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,404	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	UTILIZATION REVIEW-SNF	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - OLD CAP REL COSTS-BLDG & FIXT		0	OLD CAP REL COSTS-BLDG & FIXT	1.01	0	26.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0143

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

Worksheet A-8

Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00	2.00	3.00	4.00	5.00			
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - OLD CAP REL COSTS-MVBLE EQUIP			OLD CAP REL COSTS-MVBLE EQUIP	2.01	0	27.01
28.00	Non-physician Anesthetist			*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant				0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.00
33.01	OUTSIDE PHYSICAL THERAPY	B	-1,384	PHYSICAL THERAPY	66.00	0	33.01
33.03	OB COMISSIONS	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.04
33.06	PATIENT PHONES	A	-22,266	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	PATIENT PHONES DEPRECIATION	A	-9,248	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	33.07
33.10	MISC INCOME	B	-1,260	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	PHYSICIAN RECRUITMENT	A	-177,174	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	EMPLOYEE HEALTH	A	-1,131,014	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.13
33.15	ADMIN COSTS FOR POB	A	956	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.16
33.17	LOBBYING PORTION OF IHHA DUES	A	-27,615	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.18
34.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	34.00
35.00	HOSPITALIST RECEPTIONIST & OTHER EXP	A	-61,909	ADULTS & PEDIATRICS	30.00	0	35.00
36.00	QUALITY REVENUE	B	-4,735	NURSING ADMINISTRATION	13.00	0	36.00
37.00	LEADERSHIP CONFERENCE SPOUSE COSTS	A	-14,231	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	38.00
39.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	39.00
40.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	40.00
41.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	41.00
42.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	42.00
43.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	43.00
44.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	44.00
45.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-13,086,279				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0143

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

Worksheet A-8-1

Date/Time Prepared:
2/26/2020 11:17 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	1,774,532	1,613,272	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	SISTERS SALARIES	0	4,000	2.00
3.00	2.01	OLD CAP REL COSTS-MVBLE EQUI	OLD CAPITAL COSTS	49	0	3.00
4.00	2.00	NEW CAP REL COSTS-MVBLE EQUI	NEW CAPITAL COSTS	8,204	0	4.00
5.00	0		0	1,782,785	1,617,272	5.00

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:						

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

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

6.00	B		0.00	SRS OF MARY OF THE PRES	100.00	6.00
7.00	G	SMP HEALTH CORP	0.00	SMP HEALTH CORP	0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	NON-FINANCIAL				100.00

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

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

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

Provider CCN: 14-0143

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

Worksheet A-8-1

Date/Time Prepared:
2/26/2020 11:17 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	161,260	0		1.00
2.00	-4,000	0		2.00
3.00	49	9		3.00
4.00	8,204	9		4.00
5.00	165,513			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:			

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

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

6.00	RELIGIOUS COMMUNITY		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0143

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

Worksheet A-8-2

Date/Time Prepared:
2/26/2020 11:17 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	53.00	ANESTHESIOLOGY	1,749,000	1,565,792	183,208	239,400	218	1.00
2.00	91.00	EMERGENCY	1,219,612	791,772	427,840	179,000	3,073	2.00
3.00	43.00	NURSERY	127,500	127,500	0	0	0	3.00
4.00	60.00	LABORATORY	35,000	0	35,000	260,300	520	4.00
5.00	69.00	ELECTROCARDIOLOGY	20,800	20,800	0	0	0	5.00
6.00	31.00	INTENSIVE CARE UNIT	10,200	10,200	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	773,087	764,419	8,668	211,500	54	7.00
8.00	30.00	ADULTS & PEDIATRICS	72,498	0	72,498	211,500	362	8.00
9.00	90.00	CLINIC	7,098,343	7,098,343	0	0	0	9.00
10.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	296,344	296,344	0	0	0	10.00
11.00	90.00	CLINIC	8,501	8,501	0	0	0	11.00
12.00	16.00	MEDICAL RECORDS & LIBRARY	6,583	0	6,583	211,500	110	12.00
13.00	90.00	CLINIC	197,175	197,175	0	0	0	13.00
200.00			11,614,643	10,880,846	733,797		4,337	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	53.00	ANESTHESIOLOGY	25,091	1,255	0	0	0	1.00
2.00	91.00	EMERGENCY	264,455	13,223	0	0	0	2.00
3.00	43.00	NURSERY	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	65,075	3,254	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	5,491	275	0	0	0	7.00
8.00	30.00	ADULTS & PEDIATRICS	36,809	1,840	0	0	0	8.00
9.00	90.00	CLINIC	0	0	0	0	0	9.00
10.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	10.00
11.00	90.00	CLINIC	0	0	0	0	0	11.00
12.00	16.00	MEDICAL RECORDS & LIBRARY	11,185	559	0	0	0	12.00
13.00	90.00	CLINIC	0	0	0	0	0	13.00
200.00			408,106	20,406	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	53.00	ANESTHESIOLOGY	0	25,091	158,117	1,723,909		1.00
2.00	91.00	EMERGENCY	0	264,455	163,385	955,157		2.00
3.00	43.00	NURSERY	0	0	0	127,500		3.00
4.00	60.00	LABORATORY	0	65,075	0	0		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	20,800		5.00
6.00	31.00	INTENSIVE CARE UNIT	0	0	0	10,200		6.00
7.00	30.00	ADULTS & PEDIATRICS	0	5,491	3,177	767,596		7.00
8.00	30.00	ADULTS & PEDIATRICS	0	36,809	35,689	35,689		8.00
9.00	90.00	CLINIC	0	0	0	7,098,343		9.00
10.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	296,344		10.00
11.00	90.00	CLINIC	0	0	0	8,501		11.00
12.00	16.00	MEDICAL RECORDS & LIBRARY	0	11,185	0	0		12.00
13.00	90.00	CLINIC	0	0	0	197,175		13.00
200.00			0	408,106	360,368	11,241,214		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Description			CAPITAL RELATED COSTS					
			Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	OLD BLDG & FIXT	NEW MVBLE EQUIP		OLD MVBLE EQUIP
			0	1.00	1.01	2.00	2.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	3,182,560	3,182,560				1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT	450	0	450			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	3,072,810			3,072,810		2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP	49			0	49	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,552,673	11,054	2	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,682,944	1,125,426	160	812,175	49	5.00
7.00	00700	OPERATION OF PLANT	2,212,904	299,861	42	7,205	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	198,006	7,936	1	0	0	8.00
9.00	00900	HOUSEKEEPING	758,729	31,672	4	13,290	0	9.00
10.00	01000	DIETARY	296,637	78,776	11	21,239	0	10.00
11.00	01100	CAFETERIA	725,320	27,085	4	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,278,683	27,185	4	3,855	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,819,853	41,926	6	25,712	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,561,028	237,107	34	124,882	0	30.00
31.00	03100	INTENSIVE CARE UNIT	818,034	50,921	7	43,770	0	31.00
43.00	04300	NURSERY	76,712	12,203	2	33,979	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,764,831	274,636	39	464,685	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	437,467	6,147	1	22,317	0	52.00
53.00	05300	ANESTHESIOLOGY	205,251	4,607	1	15,234	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,148,586	80,105	11	573,954	0	54.00
54.01	05402	NUCLEAR MEDICINE	567,051	20,968	3	94,770	0	54.01
57.00	05700	CT SCAN	393,915	6,496	1	149,451	0	57.00
60.00	06000	LABORATORY	3,159,454	39,068	6	47,697	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	210,273	2,339	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	470,135	15,591	2	17,803	0	65.00
66.00	06600	PHYSICAL THERAPY	1,500,648	104,511	15	4,005	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	173,259	390	0	595	0	67.00
68.00	06800	SPEECH PATHOLOGY	121,274	1,759	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	254,722	1,319	0	9,965	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	133,000	13,313	2	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	290,382	73,918	10	33,782	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,357,702	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,801,065	24,626	3	36,054	0	73.00
76.00	03020	SONOGRAPHY	552,063	5,347	1	26,293	0	76.00
76.01	03040	AUDIOLOGY	252,381	0	0	0	0	76.01
76.02	03160	CARDIAC REHAB	216,141	14,902	2	7,801	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	13,459,594	180,209	25	362,226	0	90.00
91.00	09100	EMERGENCY	1,730,288	97,975	14	110,098	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	762,146	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	1,385,534	9,735	1	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	75,584,554	2,929,113	414	3,062,837	49	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,342	2	0	0	190.00
194.00	07950	CONGREGATE LIVING	42,873	0	0	0	0	194.00
194.01	07951	OTHER	0	132,665	19	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	56,810	0	0	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	0	78,456	11	0	0	194.04
194.05	07955	SPECIALTY CLINICS	1,745	0	0	866	0	194.05
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	625,755	28,984	4	7,959	0	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16

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COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	OLD BLDG & FIXT	NEW MVBLE EQUIP	OLD MVBLE EQUIP	
			0	1.00	1.01	2.00	2.01	
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20	07970	PARATRANSIT	166,455	0	0	0	0	194.20
194.21	07971	OCCUPATIONAL HEALTH	259,290	0	0	0	0	194.21
194.24	07974	SURGICAL ASSOCIATES	221	0	0	0	0	194.24
194.27	07977	MIDTOWN	0	0	0	1,148	0	194.27
194.28	07978	PAIN CLINIC	206,607	0	0	0	0	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
194.31	07981	CFH	0	0	0	0	0	194.31
194.32	07982	PFS	0	0	0	0	0	194.32
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	76,944,310	3,182,560	450	3,072,810	49	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	4A	5.00	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,563,729					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	702,004	13,322,758	13,322,758			5.00
7.00	00700	OPERATION OF PLANT	123,460	2,643,472	553,559	3,197,031		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,400	215,343	45,094	14,529	274,966	8.00
9.00	00900	HOUSEKEEPING	114,335	918,030	192,241	57,986	0	9.00
10.00	01000	DIETARY	41,640	438,303	91,783	144,225	0	10.00
11.00	01100	CAFETERIA	135,101	887,510	185,850	49,588	0	11.00
13.00	01300	NURSING ADMINISTRATION	257,688	1,567,415	328,226	49,771	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	314,076	2,201,573	461,023	76,760	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	807,199	4,730,250	990,543	434,102	178,818	30.00
31.00	03100	INTENSIVE CARE UNIT	170,639	1,083,371	226,864	93,228	14,656	31.00
43.00	04300	NURSERY	12,193	135,089	28,288	22,342	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	464,608	7,968,799	1,668,714	502,814	29,147	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	81,767	547,699	114,691	11,253	0	52.00
53.00	05300	ANESTHESIOLOGY	0	225,093	47,136	8,435	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	199,678	3,002,334	628,707	146,659	18,340	54.00
54.01	05402	NUCLEAR MEDICINE	28,070	710,862	148,859	38,389	0	54.01
57.00	05700	CT SCAN	30,741	580,604	121,582	11,894	3,657	57.00
60.00	06000	LABORATORY	222,883	3,469,108	726,452	71,527	137	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	212,612	44,522	4,282	0	63.00
65.00	06500	RESPIRATORY THERAPY	87,359	590,890	123,736	28,545	537	65.00
66.00	06600	PHYSICAL THERAPY	297,607	1,906,786	399,292	191,342	14,656	66.00
67.00	06700	OCCUPATIONAL THERAPY	36,456	210,700	44,122	714	0	67.00
68.00	06800	SPEECH PATHOLOGY	15,321	138,354	28,972	3,220	0	68.00
69.00	06900	ELECTROCARDIOLOGY	23,021	289,027	60,524	2,415	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14,012	160,327	33,573	24,373	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,667	406,759	85,178	135,332	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,357,702	493,717	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	173,009	3,034,757	635,496	45,086	0	73.00
76.00	03020	SONOGRAPHY	41,678	625,382	130,959	9,789	0	76.00
76.01	03040	AUDIOLOGY	0	252,381	52,850	0	0	76.01
76.02	03160	CARDIAC REHAB	42,172	281,018	58,847	27,282	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	1,588,869	15,590,923	3,264,858	329,932	0	90.00
91.00	09100	EMERGENCY	219,024	2,157,399	451,772	179,376	14,656	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	762,146	159,598	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
116.00	11600	HOSPICE	121,762	1,517,032	317,676	17,822	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,384,439	75,141,808	12,945,304	2,733,012	274,604	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,344	2,794	24,428	0	190.00
194.00	07950	CONGREGATE LIVING	0	42,873	8,978	0	0	194.00
194.01	07951	OTHER	7,881	140,565	29,435	242,888	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	10,369	67,179	14,068	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	0	78,467	16,431	143,639	0	194.04
194.05	07955	SPECIALTY CLINICS	0	2,611	547	0	362	194.05
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	53,639	716,341	150,006	53,064	0	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20	07970	PARATRANSIT	26,991	193,446	40,509	0	0	194.20

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COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		4.00	4A	5.00	7.00	8.00	
194.21	07971	OCCUPATIONAL HEALTH	49,793	309,083	64,724	0	0 194.21
194.24	07974	SURGICAL ASSOCIATES	0	221	46	0	0 194.24
194.27	07977	MIDTOWN	0	1,148	240	0	0 194.27
194.28	07978	PAIN CLINIC	30,617	237,224	49,676	0	0 194.28
194.30	07980	WHC-PTON	0	0	0	0	0 194.30
194.31	07981	CFH	0	0	0	0	0 194.31
194.32	07982	PFS	0	0	0	0	0 194.32
200.00		Cross Foot Adjustments		0			200.00
201.00		Negative Cost Centers	0	0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	6,563,729	76,944,310	13,322,758	3,197,031	274,966 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	1,168,257					9.00
10.00	01000	DIETARY	58,002	732,313				10.00
11.00	01100	CAFETERIA	46,271	0	1,169,219			11.00
13.00	01300	NURSING ADMINISTRATION	34,767	0	50,143	2,030,322		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	70,297	0	137,613	0	2,947,266	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	446,429	495,768	243,071	897,549	146,862	30.00
31.00	03100	INTENSIVE CARE UNIT	57,521	88,863	49,424	182,413	23,037	31.00
43.00	04300	NURSERY	5,286	0	7,330	26,992	8,226	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	92,995	0	159,020	587,227	456,564	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	23,319	0	22,756	84,025	13,221	52.00
53.00	05300	ANESTHESIOLOGY	961	0	0	0	87,774	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	34,569	0	74,473	0	209,825	54.00
54.01	05402	NUCLEAR MEDICINE	2,092	0	10,029	0	37,947	54.01
57.00	05700	CT SCAN	2,092	0	6,881	0	216,332	57.00
60.00	06000	LABORATORY	23,291	0	94,486	0	480,424	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,459	0	0	0	4,709	63.00
65.00	06500	RESPIRATORY THERAPY	5,625	0	30,896	0	45,195	65.00
66.00	06600	PHYSICAL THERAPY	11,589	0	0	0	121,663	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	15,211	67.00
68.00	06800	SPEECH PATHOLOGY	2,092	0	0	0	5,703	68.00
69.00	06900	ELECTROCARDIOLOGY	3,618	0	8,230	0	67,697	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	820	0	6,386	0	17,231	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,625	0	5,711	0	138,554	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	52,701	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,291	0	42,588	0	92,176	73.00
76.00	03020	SONOGRAPHY	2,092	0	10,613	0	98,342	76.00
76.01	03040	AUDIOLOGY	2,092	0	0	0	5,771	76.01
76.02	03160	CARDIAC REHAB	0	0	0	0	16,196	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	84,772	0	90,037	90.00
91.00	09100	EMERGENCY	23,291	0	68,267	252,116	128,992	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	8,779	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	37,911	0	47,112	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	980,486	584,631	1,150,600	2,030,322	2,636,281	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,092	0	0	0	0	190.00
194.00	07950	CONGREGATE LIVING	0	0	0	0	49,315	194.00
194.01	07951	OTHER	0	147,682	3,913	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	38,366	194.02
194.03	07953	MANAGED CARE	0	0	2,878	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	185,679	0	0	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	0	0	0	8,403	194.05
194.08	07958	ENT	0	0	0	0	20,029	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	0	0	0	7,393	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	44,921	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	26,844	194.13
194.14	07964	HENRY	0	0	0	0	2,127	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	1,404	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	1,987	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	31,322	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	4,910	194.19
194.20	07970	PARATRANSIT	0	0	0	0	0	194.20

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COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	MEDICAL RECORDS & LIBRARY	
		9.00	10.00	11.00	13.00	16.00	
194.21	07971 OCCUPATIONAL HEALTH	0	0	11,828	0	4,814	194.21
194.24	07974 SURGICAL ASSOCIATES	0	0	0	0	0	194.24
194.27	07977 MIDTOWN	0	0	0	0	39,286	194.27
194.28	07978 PAIN CLINIC	0	0	0	0	2,253	194.28
194.30	07980 WHC-PTON	0	0	0	0	9,474	194.30
194.31	07981 CFH	0	0	0	0	18,137	194.31
194.32	07982 PFS	0	0	0	0	0	194.32
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)	1,168,257	732,313	1,169,219	2,030,322	2,947,266	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	0				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	8,563,392	0	8,563,392	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,819,377	0	1,819,377	31.00
43.00	04300	NURSERY	0	233,553	0	233,553	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	11,465,280	0	11,465,280	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	816,964	0	816,964	52.00
53.00	05300	ANESTHESIOLOGY	0	369,399	0	369,399	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,114,907	0	4,114,907	54.00
54.01	05402	NUCLEAR MEDICINE	0	948,178	0	948,178	54.01
57.00	05700	CT SCAN	0	943,042	0	943,042	57.00
60.00	06000	LABORATORY	0	4,865,425	0	4,865,425	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	268,584	0	268,584	63.00
65.00	06500	RESPIRATORY THERAPY	0	825,424	0	825,424	65.00
66.00	06600	PHYSICAL THERAPY	0	2,645,328	0	2,645,328	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	270,747	0	270,747	67.00
68.00	06800	SPEECH PATHOLOGY	0	178,341	0	178,341	68.00
69.00	06900	ELECTROCARDIOLOGY	0	431,511	0	431,511	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	242,710	0	242,710	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	777,159	0	777,159	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,904,120	0	2,904,120	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,873,394	0	3,873,394	73.00
76.00	03020	SONOGRAPHY	0	877,177	0	877,177	76.00
76.01	03040	AUDIOLOGY	0	313,094	0	313,094	76.01
76.02	03160	CARDIAC REHAB	0	383,343	0	383,343	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	19,360,522	0	19,360,522	90.00
91.00	09100	EMERGENCY	0	3,275,869	0	3,275,869	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	930,523	0	930,523	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	1,937,553	0	1,937,553	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	73,634,916	0	73,634,916	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	42,658	0	42,658	190.00
194.00	07950	CONGREGATE LIVING	0	101,166	0	101,166	194.00
194.01	07951	OTHER	0	564,483	0	564,483	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	38,366	0	38,366	194.02
194.03	07953	MANAGED CARE	0	84,125	0	84,125	194.03
194.04	07954	RENTAL AREA/PPOS	0	424,216	0	424,216	194.04
194.05	07955	SPECIALTY CLINICS	0	11,923	0	11,923	194.05
194.08	07958	ENT	0	20,029	0	20,029	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	926,804	0	926,804	194.09
194.10	07960	PERU MALL	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	44,921	0	44,921	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	26,844	0	26,844	194.13
194.14	07964	HENRY	0	2,127	0	2,127	194.14
194.16	07966	SPRING VALLEY CLINIC	0	1,404	0	1,404	194.16
194.17	07967	OGLESBY MP OB	0	1,987	0	1,987	194.17
194.18	07968	FAMILY HEALTH CENTER	0	31,322	0	31,322	194.18

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COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
194.19	07969	GRANVILLE CLINIC	0	4,910	0	4,910		194.19
194.20	07970	PARATRANSIT	0	233,955	0	233,955		194.20
194.21	07971	OCCUPATIONAL HEALTH	0	390,449	0	390,449		194.21
194.24	07974	SURGICAL ASSOCIATES	0	267	0	267		194.24
194.27	07977	MIDTOWN	0	40,674	0	40,674		194.27
194.28	07978	PAIN CLINIC	0	289,153	0	289,153		194.28
194.30	07980	WHC-PTON	0	9,474	0	9,474		194.30
194.31	07981	CFH	0	18,137	0	18,137		194.31
194.32	07982	PFS	0	0	0	0		194.32
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	76,944,310	0	76,944,310		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Description			CAPITAL RELATED COSTS					
			Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	OLD BLDG & FIXT	NEW MVBLE EQUIP		OLD MVBLE EQUIP
			0	1.00	1.01	2.00	2.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	11,054	2	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,776	1,125,426	160	812,175	49	5.00
7.00	00700	OPERATION OF PLANT	3,835	299,861	42	7,205	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,936	1	0	0	8.00
9.00	00900	HOUSEKEEPING	2,040	31,672	4	13,290	0	9.00
10.00	01000	DIETARY	0	78,776	11	21,239	0	10.00
11.00	01100	CAFETERIA	0	27,085	4	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	27,185	4	3,855	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	41,926	6	25,712	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	53,533	237,107	34	124,882	0	30.00
31.00	03100	INTENSIVE CARE UNIT	8,641	50,921	7	43,770	0	31.00
43.00	04300	NURSERY	0	12,203	2	33,979	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	153,524	274,636	39	464,685	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,147	1	22,317	0	52.00
53.00	05300	ANESTHESIOLOGY	31,668	4,607	1	15,234	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,095	80,105	11	573,954	0	54.00
54.01	05402	NUCLEAR MEDICINE	0	20,968	3	94,770	0	54.01
57.00	05700	CT SCAN	0	6,496	1	149,451	0	57.00
60.00	06000	LABORATORY	0	39,068	6	47,697	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	2,339	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	9,204	15,591	2	17,803	0	65.00
66.00	06600	PHYSICAL THERAPY	9,200	104,511	15	4,005	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	390	0	595	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,759	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,319	0	9,965	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	13,313	2	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	73,918	10	33,782	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	2,460	24,626	3	36,054	0	73.00
76.00	03020	SONOGRAPHY	0	5,347	1	26,293	0	76.00
76.01	03040	AUDIOLOGY	0	0	0	0	0	76.01
76.02	03160	CARDIAC REHAB	0	14,902	2	7,801	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	1,461	180,209	25	362,226	0	90.00
91.00	09100	EMERGENCY	9,696	97,975	14	110,098	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	41,055	9,735	1	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	380,188	2,929,113	414	3,062,837	49	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,342	2	0	0	190.00
194.00	07950	CONGREGATE LIVING	0	0	0	0	0	194.00
194.01	07951	OTHER	0	132,665	19	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	0	0	0	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	0	78,456	11	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	0	0	866	0	194.05
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	86	28,984	4	7,959	0	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17

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ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	OLD BLDG & FIXT	NEW MVBLE EQUIP	OLD MVBLE EQUIP	
			0	1.00	1.01	2.00	2.01	
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	0 194.19
194.20	07970	PARATRANSIT	0	0	0	0	0	0 194.20
194.21	07971	OCCUPATIONAL HEALTH	0	0	0	0	0	0 194.21
194.24	07974	SURGICAL ASSOCIATES	0	0	0	0	0	0 194.24
194.27	07977	MIDTOWN	0	0	0	1,148	0	0 194.27
194.28	07978	PAIN CLINIC	2,664	0	0	0	0	0 194.28
194.30	07980	WHC-PTON	0	0	0	0	0	0 194.30
194.31	07981	CFH	0	0	0	0	0	0 194.31
194.32	07982	PFS	0	0	0	0	0	0 194.32
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)	382,938	3,182,560	450	3,072,810	49	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Description			Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			2A	4.00	5.00	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	11,056	11,056				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,956,586	1,183	1,957,769			5.00
7.00	00700	OPERATION OF PLANT	310,943	208	81,345	392,496		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,937	16	6,627	1,784	16,364	8.00
9.00	00900	HOUSEKEEPING	47,006	193	28,250	7,119	0	9.00
10.00	01000	DIETARY	100,026	70	13,487	17,706	0	10.00
11.00	01100	CAFETERIA	27,089	228	27,310	6,088	0	11.00
13.00	01300	NURSING ADMINISTRATION	31,044	434	48,232	6,110	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	67,644	529	67,747	9,424	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	415,556	1,360	145,559	53,294	10,642	30.00
31.00	03100	INTENSIVE CARE UNIT	103,339	288	33,337	11,446	872	31.00
43.00	04300	NURSERY	46,184	21	4,157	2,743	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	892,884	783	245,216	61,729	1,735	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	28,465	138	16,854	1,382	0	52.00
53.00	05300	ANESTHESIOLOGY	51,510	0	6,927	1,036	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	689,165	336	92,388	18,005	1,091	54.00
54.01	05402	NUCLEAR MEDICINE	115,741	47	21,875	4,713	0	54.01
57.00	05700	CT SCAN	155,948	52	17,866	1,460	218	57.00
60.00	06000	LABORATORY	86,771	376	106,751	8,781	8	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,339	0	6,542	526	0	63.00
65.00	06500	RESPIRATORY THERAPY	42,600	147	18,183	3,504	32	65.00
66.00	06600	PHYSICAL THERAPY	117,731	502	58,676	23,491	872	66.00
67.00	06700	OCCUPATIONAL THERAPY	985	61	6,484	88	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,759	26	4,257	395	0	68.00
69.00	06900	ELECTROCARDIOLOGY	11,284	39	8,894	297	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	13,315	24	4,934	2,992	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	107,710	15	12,517	16,615	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72,551	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	63,143	292	93,386	5,535	0	73.00
76.00	03020	SONOGRAPHY	31,641	70	19,244	1,202	0	76.00
76.01	03040	AUDIOLOGY	0	0	7,766	0	0	76.01
76.02	03160	CARDIAC REHAB	22,705	71	8,647	3,349	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	543,921	2,672	479,772	40,505	0	90.00
91.00	09100	EMERGENCY	217,783	369	66,387	22,022	872	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	23,453	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	50,791	205	46,682	2,188	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,372,601	10,755	1,902,303	335,529	16,342	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,344	0	411	2,999	0	190.00
194.00	07950	CONGREGATE LIVING	0	0	1,319	0	0	194.00
194.01	07951	OTHER	132,684	13	4,325	29,819	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	0	17	2,067	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	78,467	0	2,415	17,634	0	194.04
194.05	07955	SPECIALTY CLINICS	866	0	80	0	22	194.05
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	37,033	90	22,043	6,515	0	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20	07970	PARATRANSIT	0	45	5,953	0	0	194.20

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ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	82,568					9.00
10.00	01000	DIETARY	4,099	135,388				10.00
11.00	01100	CAFETERIA	3,270	0	63,985			11.00
13.00	01300	NURSING ADMINISTRATION	2,457	0	2,744	91,021		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,968	0	7,531	0	157,843	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	31,551	91,656	13,300	40,237	7,860	30.00
31.00	03100	INTENSIVE CARE UNIT	4,065	16,429	2,705	8,178	1,233	31.00
43.00	04300	NURSERY	374	0	401	1,210	440	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,573	0	8,702	26,326	24,434	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,648	0	1,245	3,767	708	52.00
53.00	05300	ANESTHESIOLOGY	68	0	0	0	4,697	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,443	0	4,076	0	11,229	54.00
54.01	05402	NUCLEAR MEDICINE	148	0	549	0	2,031	54.01
57.00	05700	CT SCAN	148	0	377	0	11,577	57.00
60.00	06000	LABORATORY	1,646	0	5,171	0	25,825	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	174	0	0	0	252	63.00
65.00	06500	RESPIRATORY THERAPY	398	0	1,691	0	2,419	65.00
66.00	06600	PHYSICAL THERAPY	819	0	0	0	6,511	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	814	67.00
68.00	06800	SPEECH PATHOLOGY	148	0	0	0	305	68.00
69.00	06900	ELECTROCARDIOLOGY	256	0	450	0	3,623	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	58	0	349	0	922	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	398	0	313	0	7,415	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,820	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,646	0	2,331	0	4,933	73.00
76.00	03020	SONOGRAPHY	148	0	581	0	5,263	76.00
76.01	03040	AUDIOLOGY	148	0	0	0	309	76.01
76.02	03160	CARDIAC REHAB	0	0	0	0	867	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	4,639	0	4,818	90.00
91.00	09100	EMERGENCY	1,646	0	3,736	11,303	6,903	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	470	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	2,075	0	2,521	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	69,297	108,085	62,966	91,021	141,199	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	148	0	0	0	0	190.00
194.00	07950	CONGREGATE LIVING	0	0	0	0	2,639	194.00
194.01	07951	OTHER	0	27,303	214	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	2,053	194.02
194.03	07953	MANAGED CARE	0	0	158	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	13,123	0	0	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	0	0	0	450	194.05
194.08	07958	ENT	0	0	0	0	1,072	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	0	0	0	396	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	2,404	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	1,437	194.13
194.14	07964	HENRY	0	0	0	0	114	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	75	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	106	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	1,676	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	263	194.19
194.20	07970	PARATRANSIT	0	0	0	0	0	194.20

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ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
194.21	07971	OCCUPATIONAL HEALTH	0	0	647	0	258	194.21
194.24	07974	SURGICAL ASSOCIATES	0	0	0	0	0	194.24
194.27	07977	MIDTOWN	0	0	0	0	2,102	194.27
194.28	07978	PAIN CLINIC	0	0	0	0	121	194.28
194.30	07980	WHC-PTON	0	0	0	0	507	194.30
194.31	07981	CFH	0	0	0	0	971	194.31
194.32	07982	PFS	0	0	0	0	0	194.32
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)	82,568	135,388	63,985	91,021	157,843	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	0				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	811,015	0	811,015	30.00
31.00	03100	INTENSIVE CARE UNIT	0	181,892	0	181,892	31.00
43.00	04300	NURSERY	0	55,530	0	55,530	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,268,382	0	1,268,382	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	54,207	0	54,207	52.00
53.00	05300	ANESTHESIOLOGY	0	64,238	0	64,238	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	818,733	0	818,733	54.00
54.01	05402	NUCLEAR MEDICINE	0	145,104	0	145,104	54.01
57.00	05700	CT SCAN	0	187,646	0	187,646	57.00
60.00	06000	LABORATORY	0	235,329	0	235,329	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	9,833	0	9,833	63.00
65.00	06500	RESPIRATORY THERAPY	0	68,974	0	68,974	65.00
66.00	06600	PHYSICAL THERAPY	0	208,602	0	208,602	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,432	0	8,432	67.00
68.00	06800	SPEECH PATHOLOGY	0	6,890	0	6,890	68.00
69.00	06900	ELECTROCARDIOLOGY	0	24,843	0	24,843	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	22,594	0	22,594	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	144,983	0	144,983	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	75,371	0	75,371	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	171,266	0	171,266	73.00
76.00	03020	SONOGRAPHY	0	58,149	0	58,149	76.00
76.01	03040	AUDIOLOGY	0	8,223	0	8,223	76.01
76.02	03160	CARDIAC REHAB	0	35,639	0	35,639	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	1,076,327	0	1,076,327	90.00
91.00	09100	EMERGENCY	0	331,021	0	331,021	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	23,923	0	23,923	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	104,462	0	104,462	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	6,201,608	0	6,201,608	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,902	0	16,902	190.00
194.00	07950	CONGREGATE LIVING	0	3,958	0	3,958	194.00
194.01	07951	OTHER	0	194,358	0	194,358	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	2,053	0	2,053	194.02
194.03	07953	MANAGED CARE	0	2,242	0	2,242	194.03
194.04	07954	RENTAL AREA/PPOS	0	111,639	0	111,639	194.04
194.05	07955	SPECIALTY CLINICS	0	1,418	0	1,418	194.05
194.08	07958	ENT	0	1,072	0	1,072	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	66,077	0	66,077	194.09
194.10	07960	PERU MALL	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	2,404	0	2,404	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	1,437	0	1,437	194.13
194.14	07964	HENRY	0	114	0	114	194.14
194.16	07966	SPRING VALLEY CLINIC	0	75	0	75	194.16
194.17	07967	OGLESBY MP OB	0	106	0	106	194.17
194.18	07968	FAMILY HEALTH CENTER	0	1,676	0	1,676	194.18

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ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
194.19	07969	GRANVILLE CLINIC	0	263	0	263		194.19
194.20	07970	PARATRANSIT	0	5,998	0	5,998		194.20
194.21	07971	OCCUPATIONAL HEALTH	0	10,500	0	10,500		194.21
194.24	07974	SURGICAL ASSOCIATES	0	7	0	7		194.24
194.27	07977	MIDTOWN	0	3,285	0	3,285		194.27
194.28	07978	PAIN CLINIC	0	10,137	0	10,137		194.28
194.30	07980	WHC-PTON	0	507	0	507		194.30
194.31	07981	CFH	0	971	0	971		194.31
194.32	07982	PFS	0	0	0	0		194.32
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	6,638,807	0	6,638,807		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0143

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	
			NEW BLDG & FIXT (SQUARE FEET)	OLD BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	OLD MVBLE EQUIP (DOLLAR VALUE)		
			1.00	1.01	2.00	2.01	4.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	318,435				1.00	
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT	0	318,435			1.01	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2,924,690		2.00	
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP			0	95	2.01	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,106	1,106	0	0	4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	112,606	112,606	773,026	95	5.00	
7.00	00700	OPERATION OF PLANT	30,003	30,003	6,858	0	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	794	794	0	0	8.00	
9.00	00900	HOUSEKEEPING	3,169	3,169	12,649	0	9.00	
10.00	01000	DIETARY	7,882	7,882	20,215	0	10.00	
11.00	01100	CAFETERIA	2,710	2,710	0	0	11.00	
13.00	01300	NURSING ADMINISTRATION	2,720	2,720	3,669	0	13.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	4,195	4,195	24,473	0	16.00	
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	23,724	23,724	118,862	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	5,095	5,095	41,660	0	31.00	
43.00	04300	NURSERY	1,221	1,221	32,341	0	43.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	27,479	27,479	442,285	0	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	615	615	21,241	0	52.00	
53.00	05300	ANESTHESIOLOGY	461	461	14,500	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,015	8,015	546,287	0	54.00	
54.01	05402	NUCLEAR MEDICINE	2,098	2,098	90,202	0	54.01	
57.00	05700	CT SCAN	650	650	142,247	0	57.00	
60.00	06000	LABORATORY	3,909	3,909	45,398	0	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	234	234	0	0	63.00	
65.00	06500	RESPIRATORY THERAPY	1,560	1,560	16,945	0	65.00	
66.00	06600	PHYSICAL THERAPY	10,457	10,457	3,812	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	39	39	566	0	67.00	
68.00	06800	SPEECH PATHOLOGY	176	176	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	132	132	9,485	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	1,332	1,332	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,396	7,396	32,154	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	2,464	2,464	34,316	0	73.00	
76.00	03020	SONOGRAPHY	535	535	25,026	0	76.00	
76.01	03040	AUDIOLOGY	0	0	0	0	76.01	
76.02	03160	CARDIAC REHAB	1,491	1,491	7,425	0	76.02	
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00	
90.00	09000	CLINIC	18,031	18,031	344,765	0	90.00	
91.00	09100	EMERGENCY	9,803	9,803	104,791	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00	
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00	
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE					113.00	
114.00	11400	UTILIZATION REVIEW-SNF					114.00	
116.00	11600	HOSPICE	974	974	0	0	116.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	293,076	293,076	2,915,198	95	118.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,335	1,335	0	0	190.00	
194.00	07950	CONGREGATE LIVING	0	0	0	0	194.00	
194.01	07951	OTHER	13,274	13,274	0	0	194.01	
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	194.02	
194.03	07953	MANAGED CARE	0	0	0	0	194.03	
194.04	07954	RENTAL AREA/PPOS	7,850	7,850	0	0	194.04	
194.05	07955	SPECIALTY CLINICS	0	0	824	0	194.05	
194.08	07958	ENT	0	0	0	0	194.08	
194.09	07959	DURABLE MEDICAL EQUIPMENT	2,900	2,900	7,575	0	194.09	
194.10	07960	PERU MALL	0	0	0	0	194.10	
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	194.12	
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	194.13	
194.14	07964	HENRY	0	0	0	0	194.14	
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	194.16	

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0143

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	
			NEW BLDG & FIXT (SQUARE FEET)	OLD BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	OLD MVBLE EQUIP (DOLLAR VALUE)		
			1.00	1.01	2.00	2.01	4.00	
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20	07970	PARATRANSIT	0	0	0	0	124,617	194.20
194.21	07971	OCCUPATIONAL HEALTH	0	0	0	0	229,891	194.21
194.24	07974	SURGICAL ASSOCIATES	0	0	0	0	0	194.24
194.27	07977	MIDTOWN	0	0	1,093	0	0	194.27
194.28	07978	PAIN CLINIC	0	0	0	0	141,358	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
194.31	07981	CFH	0	0	0	0	0	194.31
194.32	07982	PFS	0	0	0	0	0	194.32
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)	3,182,560	450	3,072,810	49	6,563,729	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.994379	0.001413	1.050645	0.515789	0.216594	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					11,056	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000365	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: 14-0143

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

Worksheet B-1

Date/Time Prepared:

2/26/2020 11:17 am

Cost Center Description		Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
		5A	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-13,322,758	63,621,552			5.00
7.00	00700	OPERATION OF PLANT	0	2,643,472	174,720		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	215,343	794	318,922	8.00
9.00	00900	HOUSEKEEPING	0	918,030	3,169	0	41,331 9.00
10.00	01000	DIETARY	0	438,303	7,882	0	2,052 10.00
11.00	01100	CAFETERIA	0	887,510	2,710	0	1,637 11.00
13.00	01300	NURSING ADMINISTRATION	0	1,567,415	2,720	0	1,230 13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,201,573	4,195	0	2,487 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	4,730,250	23,724	207,403	15,794 30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,083,371	5,095	16,999	2,035 31.00
43.00	04300	NURSERY	0	135,089	1,221	0	187 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	7,968,799	27,479	33,806	3,290 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	547,699	615	0	825 52.00
53.00	05300	ANESTHESIOLOGY	0	225,093	461	0	34 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,002,334	8,015	21,272	1,223 54.00
54.01	05402	NUCLEAR MEDICINE	0	710,862	2,098	0	74 54.01
57.00	05700	CT SCAN	0	580,604	650	4,242	74 57.00
60.00	06000	LABORATORY	0	3,469,108	3,909	159	824 60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0 60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	212,612	234	0	87 63.00
65.00	06500	RESPIRATORY THERAPY	0	590,890	1,560	623	199 65.00
66.00	06600	PHYSICAL THERAPY	0	1,906,786	10,457	16,999	410 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	210,700	39	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	138,354	176	0	74 68.00
69.00	06900	ELECTROCARDIOLOGY	0	289,027	132	0	128 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	160,327	1,332	0	29 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	406,759	7,396	0	199 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,357,702	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,034,757	2,464	0	824 73.00
76.00	03020	SONOGRAPHY	0	625,382	535	0	74 76.00
76.01	03040	AUDIOLOGY	0	252,381	0	0	74 76.01
76.02	03160	CARDIAC REHAB	0	281,018	1,491	0	0 76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
90.00	09000	CLINIC	0	15,590,923	18,031	0	0 90.00
91.00	09100	EMERGENCY	0	2,157,399	9,803	16,999	824 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0 93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	762,146	0	0	0 95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	1,517,032	974	0	0 116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-13,322,758	61,819,050	149,361	318,502	34,688 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,344	1,335	0	74 190.00
194.00	07950	CONGREGATE LIVING	0	42,873	0	0	0 194.00
194.01	07951	OTHER	0	140,565	13,274	0	0 194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0 194.02
194.03	07953	MANAGED CARE	0	67,179	0	0	0 194.03
194.04	07954	RENTAL AREA/PPOS	0	78,467	7,850	0	6,569 194.04
194.05	07955	SPECIALTY CLINICS	0	2,611	0	420	0 194.05
194.08	07958	ENT	0	0	0	0	0 194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	716,341	2,900	0	0 194.09
194.10	07960	PERU MALL	0	0	0	0	0 194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0 194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0 194.13
194.14	07964	HENRY	0	0	0	0	0 194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0 194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	0 194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0 194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0 194.19

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0143

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

Worksheet B-1

Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Description			Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
			5A	5.00	7.00	8.00	9.00	
194.20	07970	PARATRANSIT	0	193,446	0	0	0	194.20
194.21	07971	OCCUPATIONAL HEALTH	0	309,083	0	0	0	194.21
194.24	07974	SURGICAL ASSOCIATES	0	221	0	0	0	194.24
194.27	07977	MIDTOWN	0	1,148	0	0	0	194.27
194.28	07978	PAIN CLINIC	0	237,224	0	0	0	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
194.31	07981	CFH	0	0	0	0	0	194.31
194.32	07982	PFS	0	0	0	0	0	194.32
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)		13,322,758	3,197,031	274,966	1,168,257	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.209406	18.298025	0.862173	28.265878	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		1,957,769	392,496	16,364	82,568	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.030772	2.246429	0.051310	1.997726	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: 14-0143

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

Worksheet B-1

Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Description			DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATIO N (HOURS OF SERVICE)	MEDICAL RECORDS & LIBRARY (PATIENT CHARGES)	SOCIAL SERVICE (TIME SPENT)	
			10.00	11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	22,572					10.00
11.00	01100	CAFETERIA	0	25,999				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,115	254,318			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,060	0	258,153,243		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,281	5,405	112,427	12,863,471	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,739	1,099	22,849	2,017,745	0	31.00
43.00	04300	NURSERY	0	163	3,381	720,485	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	3,536	73,556	39,989,849	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	506	10,525	1,158,039	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	7,687,976	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,656	0	18,378,291	0	54.00
54.01	05402	NUCLEAR MEDICINE	0	223	0	3,323,745	0	54.01
57.00	05700	CT SCAN	0	153	0	18,948,270	0	57.00
60.00	06000	LABORATORY	0	2,101	0	42,085,839	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	412,424	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	687	0	3,958,584	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	10,656,275	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,332,346	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	499,536	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	183	0	5,929,526	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	142	0	1,509,242	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	127	0	12,135,790	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,615,975	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	947	0	8,073,608	0	73.00
76.00	03020	SONOGRAPHY	0	236	0	8,613,646	0	76.00
76.01	03040	AUDIOLOGY	0	0	0	505,470	0	76.01
76.02	03160	CARDIAC REHAB	0	0	0	1,418,559	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	1,885	0	7,886,210	0	90.00
91.00	09100	EMERGENCY	0	1,518	31,580	11,298,260	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	768,898	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	843	0	4,126,456	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,020	25,585	254,318	230,914,515	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	CONGREGATE LIVING	0	0	0	4,319,417	0	194.00
194.01	07951	OTHER	4,552	87	0	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	3,360,433	0	194.02
194.03	07953	MANAGED CARE	0	64	0	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	0	0	0	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	0	0	736,050	0	194.05
194.08	07958	ENT	0	0	0	1,754,335	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	0	0	647,529	0	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	3,934,571	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	2,351,194	0	194.13
194.14	07964	HENRY	0	0	0	186,333	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	122,999	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	174,057	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	2,743,432	0	194.18

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0143

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

Worksheet B-1

Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Description			DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATIO N (HOURS OF SERVICE)	MEDICAL RECORDS & LIBRARY (PATIENT CHARGES)	SOCIAL SERVICE (TIME SPENT)	
			10.00	11.00	13.00	16.00	17.00	
194.19	07969	GRANVILLE CLINIC	0	0	0	430,039	0	194.19
194.20	07970	PARATRANSIT	0	0	0	0	0	194.20
194.21	07971	OCCUPATIONAL HEALTH	0	263	0	421,616	0	194.21
194.24	07974	SURGICAL ASSOCIATES	0	0	0	0	0	194.24
194.27	07977	MIDTOWN	0	0	0	3,441,052	0	194.27
194.28	07978	PAIN CLINIC	0	0	0	197,313	0	194.28
194.30	07980	WHC-PTON	0	0	0	829,784	0	194.30
194.31	07981	CFH	0	0	0	1,588,574	0	194.31
194.32	07982	PFS	0	0	0	0	0	194.32
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)	732,313	1,169,219	2,030,322	2,947,266	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	32.443425	44.971691	7.983399	0.011417	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	135,388	63,985	91,021	157,843	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.998051	2.461056	0.357902	0.000611	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/26/2020 11:17 am

			Title XVIII	Hospital	PPS			
Cost Center Description			Therapy Limit Adj.	Costs				
				Total Costs	RCE Disallowance		Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,563,392		8,563,392	38,866	8,602,258	30.00
31.00	03100	INTENSIVE CARE UNIT	1,819,377		1,819,377	0	1,819,377	31.00
43.00	04300	NURSERY	233,553		233,553	0	233,553	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,465,280		11,465,280	0	11,465,280	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	816,964		816,964	0	816,964	52.00
53.00	05300	ANESTHESIOLOGY	369,399		369,399	158,117	527,516	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,114,907		4,114,907	0	4,114,907	54.00
54.01	05402	NUCLEAR MEDICINE	948,178		948,178	0	948,178	54.01
57.00	05700	CT SCAN	943,042		943,042	0	943,042	57.00
60.00	06000	LABORATORY	4,865,425		4,865,425	0	4,865,425	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	268,584		268,584	0	268,584	63.00
65.00	06500	RESPIRATORY THERAPY	825,424	0	825,424	0	825,424	65.00
66.00	06600	PHYSICAL THERAPY	2,645,328	0	2,645,328	0	2,645,328	66.00
67.00	06700	OCCUPATIONAL THERAPY	270,747	0	270,747	0	270,747	67.00
68.00	06800	SPEECH PATHOLOGY	178,341	0	178,341	0	178,341	68.00
69.00	06900	ELECTROCARDIOLOGY	431,511		431,511	0	431,511	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	242,710		242,710	0	242,710	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	777,159		777,159	0	777,159	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,904,120		2,904,120	0	2,904,120	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,873,394		3,873,394	0	3,873,394	73.00
76.00	03020	SONOGRAPHY	877,177		877,177	0	877,177	76.00
76.01	03040	AUDIOLOGY	313,094		313,094	0	313,094	76.01
76.02	03160	CARDIAC REHAB	383,343		383,343	0	383,343	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
90.00	09000	CLINIC	19,360,522		19,360,522	0	19,360,522	90.00
91.00	09100	EMERGENCY	3,275,869		3,275,869	163,385	3,439,254	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,524,463		2,524,463	0	2,524,463	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	930,523		930,523	0	930,523	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	1,937,553		1,937,553		1,937,553	116.00
200.00		Subtotal (see instructions)	76,159,379	0	76,159,379	360,368	76,519,747	200.00
201.00		Less Observation Beds	2,524,463		2,524,463		2,524,463	201.00
202.00		Total (see instructions)	73,634,916	0	73,634,916	360,368	73,995,284	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/26/2020 11:17 am

			Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,514,359		8,514,359		30.00
31.00	03100	INTENSIVE CARE UNIT	2,009,851		2,009,851		31.00
43.00	04300	NURSERY	713,328		713,328		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,379,284	30,289,757	39,669,041	0.289023	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	945,314	201,785	1,147,099	0.712200	52.00
53.00	05300	ANESTHESIOLOGY	2,560,728	5,057,903	7,618,631	0.048486	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,860,882	16,398,161	18,259,043	0.225363	54.00
54.01	05402	NUCLEAR MEDICINE	172,623	3,134,019	3,306,642	0.286750	54.01
57.00	05700	CT SCAN	2,440,941	16,395,565	18,836,506	0.050065	57.00
60.00	06000	LABORATORY	7,445,503	34,406,890	41,852,393	0.116252	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	251,577	159,469	411,046	0.653416	63.00
65.00	06500	RESPIRATORY THERAPY	2,771,524	1,177,797	3,949,321	0.209004	65.00
66.00	06600	PHYSICAL THERAPY	969,595	9,630,690	10,600,285	0.249553	66.00
67.00	06700	OCCUPATIONAL THERAPY	153,710	1,172,409	1,326,119	0.204165	67.00
68.00	06800	SPEECH PATHOLOGY	40,203	457,503	497,706	0.358326	68.00
69.00	06900	ELECTROCARDIOLOGY	2,226,454	3,684,455	5,910,909	0.073002	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,703	1,493,873	1,495,576	0.162285	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,363,530	4,738,829	12,102,359	0.064215	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,200,052	415,923	4,615,975	0.629146	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,276,846	4,739,621	8,016,467	0.483180	73.00
76.00	03020	SONOGRAPHY	1,086,440	7,477,691	8,564,131	0.102425	76.00
76.01	03040	AUDIOLOGY	0	505,470	505,470	0.619412	76.01
76.02	03160	CARDIAC REHAB	15,928	1,394,980	1,410,908	0.271700	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	51,000	7,775,306	7,826,306	2.473775	90.00
91.00	09100	EMERGENCY	1,730,612	9,515,585	11,246,197	0.291287	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	960,852	3,343,052	4,303,904	0.586552	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	765,974	765,974	1.214823	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	4,124,865	4,124,865		116.00
200.00		Subtotal (see instructions)	61,142,839	168,457,572	229,600,411		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	61,142,839	168,457,572	229,600,411		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.289023		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.712200		52.00
53.00	05300	ANESTHESIOLOGY	0.069240		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.225363		54.00
54.01	05402	NUCLEAR MEDICINE	0.286750		54.01
57.00	05700	CT SCAN	0.050065		57.00
60.00	06000	LABORATORY	0.116252		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.653416		63.00
65.00	06500	RESPIRATORY THERAPY	0.209004		65.00
66.00	06600	PHYSICAL THERAPY	0.249553		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.204165		67.00
68.00	06800	SPEECH PATHOLOGY	0.358326		68.00
69.00	06900	ELECTROCARDIOLOGY	0.073002		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.162285		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.064215		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.629146		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.483180		73.00
76.00	03020	SONOGRAPHY	0.102425		76.00
76.01	03040	AUDIOLOGY	0.619412		76.01
76.02	03160	CARDIAC REHAB	0.271700		76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	2.473775		90.00
91.00	09100	EMERGENCY	0.305815		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.586552		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	1.214823		95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/26/2020 11:17 am

			Title XIX	Hospital	PPS			
Cost Center Description			Therapy Limit Adj.	Costs				
				Total Costs	RCE Disallowance		Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,563,392		8,563,392	38,866	8,602,258	30.00
31.00	03100	INTENSIVE CARE UNIT	1,819,377		1,819,377	0	1,819,377	31.00
43.00	04300	NURSERY	233,553		233,553	0	233,553	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,465,280		11,465,280	0	11,465,280	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	816,964		816,964	0	816,964	52.00
53.00	05300	ANESTHESIOLOGY	369,399		369,399	158,117	527,516	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,114,907		4,114,907	0	4,114,907	54.00
54.01	05402	NUCLEAR MEDICINE	948,178		948,178	0	948,178	54.01
57.00	05700	CT SCAN	943,042		943,042	0	943,042	57.00
60.00	06000	LABORATORY	4,865,425		4,865,425	0	4,865,425	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	268,584		268,584	0	268,584	63.00
65.00	06500	RESPIRATORY THERAPY	825,424	0	825,424	0	825,424	65.00
66.00	06600	PHYSICAL THERAPY	2,645,328	0	2,645,328	0	2,645,328	66.00
67.00	06700	OCCUPATIONAL THERAPY	270,747	0	270,747	0	270,747	67.00
68.00	06800	SPEECH PATHOLOGY	178,341	0	178,341	0	178,341	68.00
69.00	06900	ELECTROCARDIOLOGY	431,511		431,511	0	431,511	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	242,710		242,710	0	242,710	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	777,159		777,159	0	777,159	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,904,120		2,904,120	0	2,904,120	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,873,394		3,873,394	0	3,873,394	73.00
76.00	03020	SONOGRAPHY	877,177		877,177	0	877,177	76.00
76.01	03040	AUDIOLOGY	313,094		313,094	0	313,094	76.01
76.02	03160	CARDIAC REHAB	383,343		383,343	0	383,343	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
90.00	09000	CLINIC	19,360,522		19,360,522	0	19,360,522	90.00
91.00	09100	EMERGENCY	3,275,869		3,275,869	163,385	3,439,254	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,524,463		2,524,463	0	2,524,463	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	930,523		930,523	0	930,523	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	1,937,553		1,937,553		1,937,553	116.00
200.00		Subtotal (see instructions)	76,159,379	0	76,159,379	360,368	76,519,747	200.00
201.00		Less Observation Beds	2,524,463		2,524,463		2,524,463	201.00
202.00		Total (see instructions)	73,634,916	0	73,634,916	360,368	73,995,284	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/26/2020 11:17 am

			Title XIX			Hospital	PPS		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				9.00
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,514,359		8,514,359			30.00	
31.00	03100	INTENSIVE CARE UNIT	2,009,851		2,009,851			31.00	
43.00	04300	NURSERY	713,328		713,328			43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,379,284	30,289,757	39,669,041	0.289023	0.000000	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	945,314	201,785	1,147,099	0.712200	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	2,560,728	5,057,903	7,618,631	0.048486	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,860,882	16,398,161	18,259,043	0.225363	0.000000	54.00	
54.01	05402	NUCLEAR MEDICINE	172,623	3,134,019	3,306,642	0.286750	0.000000	54.01	
57.00	05700	CT SCAN	2,440,941	16,395,565	18,836,506	0.050065	0.000000	57.00	
60.00	06000	LABORATORY	7,445,503	34,406,890	41,852,393	0.116252	0.000000	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	251,577	159,469	411,046	0.653416	0.000000	63.00	
65.00	06500	RESPIRATORY THERAPY	2,771,524	1,177,797	3,949,321	0.209004	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	969,595	9,630,690	10,600,285	0.249553	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	153,710	1,172,409	1,326,119	0.204165	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	40,203	457,503	497,706	0.358326	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	2,226,454	3,684,455	5,910,909	0.073002	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	1,703	1,493,873	1,495,576	0.162285	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,363,530	4,738,829	12,102,359	0.064215	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,200,052	415,923	4,615,975	0.629146	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	3,276,846	4,739,621	8,016,467	0.483180	0.000000	73.00	
76.00	03020	SONOGRAPHY	1,086,440	7,477,691	8,564,131	0.102425	0.000000	76.00	
76.01	03040	AUDIOLOGY	0	505,470	505,470	0.619412	0.000000	76.01	
76.02	03160	CARDIAC REHAB	15,928	1,394,980	1,410,908	0.271700	0.000000	76.02	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00	
90.00	09000	CLINIC	51,000	7,775,306	7,826,306	2.473775	0.000000	90.00	
91.00	09100	EMERGENCY	1,730,612	9,515,585	11,246,197	0.291287	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	960,852	3,343,052	4,303,904	0.586552	0.000000	92.00	
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	765,974	765,974	1.214823	0.000000	95.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
114.00	11400	UTILIZATION REVIEW-SNF						114.00	
116.00	11600	HOSPICE	0	4,124,865	4,124,865			116.00	
200.00		Subtotal (see instructions)	61,142,839	168,457,572	229,600,411			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	61,142,839	168,457,572	229,600,411			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.289023		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.712200		52.00
53.00	05300	ANESTHESIOLOGY	0.069240		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.225363		54.00
54.01	05402	NUCLEAR MEDICINE	0.286750		54.01
57.00	05700	CT SCAN	0.050065		57.00
60.00	06000	LABORATORY	0.116252		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.653416		63.00
65.00	06500	RESPIRATORY THERAPY	0.209004		65.00
66.00	06600	PHYSICAL THERAPY	0.249553		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.204165		67.00
68.00	06800	SPEECH PATHOLOGY	0.358326		68.00
69.00	06900	ELECTROCARDIOLOGY	0.073002		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.162285		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.064215		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.629146		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.483180		73.00
76.00	03020	SONOGRAPHY	0.102425		76.00
76.01	03040	AUDIOLOGY	0.619412		76.01
76.02	03160	CARDIAC REHAB	0.271700		76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	2.473775		90.00
91.00	09100	EMERGENCY	0.305815		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.586552		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	1.214823		95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part II
Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Description		Title XIX			Hospital	PPS	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	11,465,280	1,268,382	10,196,898	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	816,964	54,207	762,757	0	0	52.00
53.00	05300 ANESTHESIOLOGY	369,399	64,238	305,161	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,114,907	818,733	3,296,174	0	0	54.00
54.01	05402 NUCLEAR MEDICINE	948,178	145,104	803,074	0	0	54.01
57.00	05700 CT SCAN	943,042	187,646	755,396	0	0	57.00
60.00	06000 LABORATORY	4,865,425	235,329	4,630,096	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	268,584	9,833	258,751	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	825,424	68,974	756,450	0	0	65.00
66.00	06600 PHYSICAL THERAPY	2,645,328	208,602	2,436,726	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	270,747	8,432	262,315	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	178,341	6,890	171,451	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	431,511	24,843	406,668	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	242,710	22,594	220,116	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	777,159	144,983	632,176	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2,904,120	75,371	2,828,749	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,873,394	171,266	3,702,128	0	0	73.00
76.00	03020 SONOGRAPHY	877,177	58,149	819,028	0	0	76.00
76.01	03040 AUDIOLOGY	313,094	8,223	304,871	0	0	76.01
76.02	03160 CARDIAC REHAB	383,343	35,639	347,704	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000 CLINIC	19,360,522	1,076,327	18,284,195	0	0	90.00
91.00	09100 EMERGENCY	3,275,869	331,021	2,944,848	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,524,463	238,004	2,286,459	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	930,523	23,923	906,600	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
114.00	11400 UTILIZATION REVIEW-SNF						114.00
116.00	11600 HOSPICE	1,937,553	104,462	1,833,091	0	0	116.00
200.00	Subtotal (sum of lines 50 thru 199)	65,543,057	5,391,175	60,151,882	0	0	200.00
201.00	Less Observation Beds	2,524,463	238,004	2,286,459	0	0	201.00
202.00	Total (line 200 minus line 201)	63,018,594	5,153,171	57,865,423	0	0	202.00

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

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part II
Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,465,280	39,669,041	0.289023	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	816,964	1,147,099	0.712200	52.00
53.00	05300	ANESTHESIOLOGY	369,399	7,618,631	0.048486	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,114,907	18,259,043	0.225363	54.00
54.01	05402	NUCLEAR MEDICINE	948,178	3,306,642	0.286750	54.01
57.00	05700	CT SCAN	943,042	18,836,506	0.050065	57.00
60.00	06000	LABORATORY	4,865,425	41,852,393	0.116252	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	268,584	411,046	0.653416	63.00
65.00	06500	RESPIRATORY THERAPY	825,424	3,949,321	0.209004	65.00
66.00	06600	PHYSICAL THERAPY	2,645,328	10,600,285	0.249553	66.00
67.00	06700	OCCUPATIONAL THERAPY	270,747	1,326,119	0.204165	67.00
68.00	06800	SPEECH PATHOLOGY	178,341	497,706	0.358326	68.00
69.00	06900	ELECTROCARDIOLOGY	431,511	5,910,909	0.073002	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	242,710	1,495,576	0.162285	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	777,159	12,102,359	0.064215	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,904,120	4,615,975	0.629146	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,873,394	8,016,467	0.483180	73.00
76.00	03020	SONOGRAPHY	877,177	8,564,131	0.102425	76.00
76.01	03040	AUDIOLOGY	313,094	505,470	0.619412	76.01
76.02	03160	CARDIAC REHAB	383,343	1,410,908	0.271700	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	88.00
90.00	09000	CLINIC	19,360,522	7,826,306	2.473775	90.00
91.00	09100	EMERGENCY	3,275,869	11,246,197	0.291287	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,524,463	4,303,904	0.586552	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	930,523	765,974	1.214823	95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
114.00	11400	UTILIZATION REVIEW-SNF				114.00
116.00	11600	HOSPICE	1,937,553	4,124,865	0.469725	116.00
200.00		Subtotal (sum of lines 50 thru 199)	65,543,057	218,362,873		200.00
201.00		Less Observation Beds	2,524,463	0		201.00
202.00		Total (line 200 minus line 201)	63,018,594	218,362,873		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part I
Date/Time Prepared:
2/26/2020 11:17 am

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	811,015	44	810,971	7,486	108.33	30.00
31.00	INTENSIVE CARE UNIT	181,892		181,892	752	241.88	31.00
43.00	NURSERY	55,530		55,530	577	96.24	43.00
200.00	Total (lines 30 through 199)	1,048,437		1,048,393	8,815		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	3,113	337,231				30.00
31.00	INTENSIVE CARE UNIT	431	104,250				31.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	3,544	441,481				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part II
Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Description		Capital Related Cost (from Wkst. C, Part I, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Program Charges	Capital Costs (column 3 x column 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,268,382	39,669,041	0.031974	4,539,782	145,155	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	54,207	1,147,099	0.047256	291	14	52.00
53.00	05300 ANESTHESIOLOGY	64,238	7,618,631	0.008432	1,261,607	10,638	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	818,733	18,259,043	0.044840	1,426,306	63,956	54.00
54.01	05402 NUCLEAR MEDICINE	145,104	3,306,642	0.043883	117,397	5,152	54.01
57.00	05700 CT SCAN	187,646	18,836,506	0.009962	1,543,763	15,379	57.00
60.00	06000 LABORATORY	235,329	41,852,393	0.005623	4,655,155	26,176	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	9,833	411,046	0.023922	175,116	4,189	63.00
65.00	06500 RESPIRATORY THERAPY	68,974	3,949,321	0.017465	765,208	13,364	65.00
66.00	06600 PHYSICAL THERAPY	208,602	10,600,285	0.019679	592,558	11,661	66.00
67.00	06700 OCCUPATIONAL THERAPY	8,432	1,326,119	0.006358	80,806	514	67.00
68.00	06800 SPEECH PATHOLOGY	6,890	497,706	0.013844	30,509	422	68.00
69.00	06900 ELECTROCARDIOLOGY	24,843	5,910,909	0.004203	1,623,935	6,825	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	22,594	1,495,576	0.015107	1,551	23	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	144,983	12,102,359	0.011980	5,980,786	71,650	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	75,371	4,615,975	0.016328	1,740,408	28,417	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	171,266	8,016,467	0.021364	1,853,834	39,605	73.00
76.00	03020 SONOGRAPHY	58,149	8,564,131	0.006790	604,130	4,102	76.00
76.01	03040 AUDIOLOGY	8,223	505,470	0.016268	0	0	76.01
76.02	03160 CARDIAC REHAB	35,639	1,410,908	0.025260	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
90.00	09000 CLINIC	1,076,327	7,826,306	0.137527	50,255	6,911	90.00
91.00	09100 EMERGENCY	331,021	11,246,197	0.029434	1,281,931	37,732	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	238,004	4,303,904	0.055300	157,013	8,683	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	5,262,790	213,472,034		28,482,341	500,568	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0143		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part III Date/Time Prepared: 2/26/2020 11:17 am		
					Title XVIII		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	0	31.00	
43.00	04300	NURSERY	0	0	0	0	0	0	0	43.00	
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	7,486	0.00	3,113	0.00	431	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	752	0.00	0	0.00	0	31.00	
43.00	04300	NURSERY	0	0	577	0.00	0	0.00	0	43.00	
200.00		Total (lines 30 through 199)	0	0	8,815		3,544			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	
43.00	04300	NURSERY	0							43.00	
200.00		Total (lines 30 through 199)	0							200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/26/2020 11:17 am

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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05402	NUCLEAR MEDICINE	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SONOGRAPHY	0	0	0	0	0	76.00
76.01	03040	AUDIOLOGY	0	0	0	0	0	76.01
76.02	03160	CARDIAC REHAB	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0143

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

Worksheet D
Part IV
Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Description			Title XVIII		Hospital		PPS
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)
			4.00	5.00	6.00	7.00	8.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	39,669,041	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,147,099	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	7,618,631	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	18,259,043	0.000000
54.01	05402	NUCLEAR MEDICINE	0	0	0	3,306,642	0.000000
57.00	05700	CT SCAN	0	0	0	18,836,506	0.000000
60.00	06000	LABORATORY	0	0	0	41,852,393	0.000000
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	411,046	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,949,321	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	10,600,285	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,326,119	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	497,706	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,910,909	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,495,576	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	12,102,359	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,615,975	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,016,467	0.000000
76.00	03020	SONOGRAPHY	0	0	0	8,564,131	0.000000
76.01	03040	AUDIOLOGY	0	0	0	505,470	0.000000
76.02	03160	CARDIAC REHAB	0	0	0	1,410,908	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000
90.00	09000	CLINIC	0	0	0	7,826,306	0.000000
91.00	09100	EMERGENCY	0	0	0	11,246,197	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	4,303,904	0.000000
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	213,472,034	
200.00		Total (lines 50 through 199)	0	0	0	213,472,034	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/26/2020 11:17 am

				Title XVIII		Hospital	PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
				9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000		4,539,782	0	8,973,721	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		291	0	27	0
53.00	05300	ANESTHESIOLOGY	0.000000		1,261,607	0	1,672,054	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		1,426,306	0	6,746,429	0
54.01	05402	NUCLEAR MEDICINE	0.000000		117,397	0	1,576,432	0
57.00	05700	CT SCAN	0.000000		1,543,763	0	5,564,522	0
60.00	06000	LABORATORY	0.000000		4,655,155	0	4,818,824	0
60.01	06001	BLOOD LABORATORY	0.000000		0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		175,116	0	65,745	0
65.00	06500	RESPIRATORY THERAPY	0.000000		765,208	0	586,943	0
66.00	06600	PHYSICAL THERAPY	0.000000		592,558	0	22,311	0
67.00	06700	OCCUPATIONAL THERAPY	0.000000		80,806	0	379	0
68.00	06800	SPEECH PATHOLOGY	0.000000		30,509	0	391	0
69.00	06900	ELECTROCARDIOLOGY	0.000000		1,623,935	0	1,599,208	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		1,551	0	121,063	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		5,980,786	0	2,163,956	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		1,740,408	0	239,573	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		1,853,834	0	3,010,135	0
76.00	03020	SONOGRAPHY	0.000000		604,130	0	1,783,514	0
76.01	03040	AUDIOLOGY	0.000000		0	0	83,417	0
76.02	03160	CARDIAC REHAB	0.000000		0	0	210,451	0
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	0	0	0
90.00	09000	CLINIC	0.000000		50,255	0	1,696,875	0
91.00	09100	EMERGENCY	0.000000		1,281,931	0	2,698,714	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		157,013	0	766,960	0
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		0	0	0	0
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						
200.00		Total (lines 50 through 199)			28,482,341	0	44,401,644	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part V
Date/Time Prepared:
2/26/2020 11:17 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.289023	8,973,721	0	0	2,593,612	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.712200	27	0	0	19	52.00
53.00	05300	ANESTHESIOLOGY	0.048486	1,672,054	0	0	81,071	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.225363	6,746,429	0	0	1,520,395	54.00
54.01	05402	NUCLEAR MEDICINE	0.286750	1,576,432	0	0	452,042	54.01
57.00	05700	CT SCAN	0.050065	5,564,522	0	0	278,588	57.00
60.00	06000	LABORATORY	0.116252	4,818,824	0	0	560,198	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.653416	65,745	0	0	42,959	63.00
65.00	06500	RESPIRATORY THERAPY	0.209004	586,943	0	0	122,673	65.00
66.00	06600	PHYSICAL THERAPY	0.249553	22,311	0	0	5,568	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.204165	379	0	0	77	67.00
68.00	06800	SPEECH PATHOLOGY	0.358326	391	0	0	140	68.00
69.00	06900	ELECTROCARDIOLOGY	0.073002	1,599,208	0	0	116,745	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.162285	121,063	0	0	19,647	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.064215	2,163,956	0	0	138,958	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.629146	239,573	0	0	150,726	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.483180	3,010,135	1,530	108,925	1,454,437	73.00
76.00	03020	SONOGRAPHY	0.102425	1,783,514	0	0	182,676	76.00
76.01	03040	AUDIOLOGY	0.619412	83,417	0	0	51,669	76.01
76.02	03160	CARDIAC REHAB	0.271700	210,451	0	0	57,180	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	2.473775	1,696,875	0	0	4,197,687	90.00
91.00	09100	EMERGENCY	0.291287	2,698,714	0	0	786,100	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.586552	766,960	0	0	449,862	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1.214823		0			95.00
200.00		Subtotal (see instructions)		44,401,644	1,530	108,925	13,263,029	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		44,401,644	1,530	108,925	13,263,029	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part V
Date/Time Prepared:
2/26/2020 11:17 am

			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05402	NUCLEAR MEDICINE	0	0		54.01
57.00	05700	CT SCAN	0	0		57.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	739	52,630		73.00
76.00	03020	SONOGRAPHY	0	0		76.00
76.01	03040	AUDIOLOGY	0	0		76.01
76.02	03160	CARDIAC REHAB	0	0		76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	739	52,630		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	739	52,630		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-0143

Period:

Worksheet D

Component CCN:14-U143

From 10/01/2018
To 09/30/2019Part V
Date/Time Prepared:
2/26/2020 11:17 am

			Title XVIII		Swing Beds - SNF		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Subject To Ded. & Coins. (see inst.)	Cost Reimbursed 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	0.289023	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.712200	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.048486	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.225363	0	0	0	0	54.00
54.01	05402	NUCLEAR MEDICINE	0.286750	0	0	0	0	54.01
57.00	05700	CT SCAN	0.050065	0	0	0	0	57.00
60.00	06000	LABORATORY	0.116252	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.653416	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.209004	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.249553	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.204165	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.358326	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.073002	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.162285	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.064215	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.629146	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.483180	0	0	0	0	73.00
76.00	03020	SONOGRAPHY	0.102425	0	0	0	0	76.00
76.01	03040	AUDIOLOGY	0.619412	0	0	0	0	76.01
76.02	03160	CARDIAC REHAB	0.271700	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	2.473775	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.291287	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.586552	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1.214823	0	0	0	0	95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-0143

Period:

Worksheet D

Component CCN:14-U143

From 10/01/2018
To 09/30/2019Part V
Date/Time Prepared:
2/26/2020 11:17 am

			Title XVIII		Swing Beds - SNF		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				
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0				
53.00	05300	ANESTHESIOLOGY	0	0				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0				
54.01	05402	NUCLEAR MEDICINE	0	0				
57.00	05700	CT SCAN	0	0				
60.00	06000	LABORATORY	0	0				
60.01	06001	BLOOD LABORATORY	0	0				
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0				
65.00	06500	RESPIRATORY THERAPY	0	0				
66.00	06600	PHYSICAL THERAPY	0	0				
67.00	06700	OCCUPATIONAL THERAPY	0	0				
68.00	06800	SPEECH PATHOLOGY	0	0				
69.00	06900	ELECTROCARDIOLOGY	0	0				
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0				
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0				
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0				
76.00	03020	SONOGRAPHY	0	0				
76.01	03040	AUDIOLOGY	0	0				
76.02	03160	CARDIAC REHAB	0	0				
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0				
90.00	09000	CLINIC	0	0				
91.00	09100	EMERGENCY	0	0				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0				
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0				
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0					
200.00		Subtotal (see instructions)	0	0				
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0					
202.00		Net Charges (line 200 - line 201)	0	0				

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part I
Date/Time Prepared:
2/26/2020 11:17 am

			Title XIX		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	811,015	44	810,971	7,486	108.33	30.00
31.00	INTENSIVE CARE UNIT	181,892		181,892	752	241.88	31.00
43.00	NURSERY	55,530		55,530	577	96.24	43.00
200.00	Total (lines 30 through 199)	1,048,437		1,048,393	8,815		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	501	54,273				30.00
31.00	INTENSIVE CARE UNIT	13	3,144				31.00
43.00	NURSERY	197	18,959				43.00
200.00	Total (lines 30 through 199)	711	76,376				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part II
Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Description			Title XIX		Hospital		PPS	
			Capital Related Cost (from Wkst. C, Part I, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,268,382	39,669,041	0.031974	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	54,207	1,147,099	0.047256	0	0	52.00
53.00	05300	ANESTHESIOLOGY	64,238	7,618,631	0.008432	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	818,733	18,259,043	0.044840	0	0	54.00
54.01	05402	NUCLEAR MEDICINE	145,104	3,306,642	0.043883	0	0	54.01
57.00	05700	CT SCAN	187,646	18,836,506	0.009962	0	0	57.00
60.00	06000	LABORATORY	235,329	41,852,393	0.005623	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	9,833	411,046	0.023922	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	68,974	3,949,321	0.017465	0	0	65.00
66.00	06600	PHYSICAL THERAPY	208,602	10,600,285	0.019679	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,432	1,326,119	0.006358	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	6,890	497,706	0.013844	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	24,843	5,910,909	0.004203	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	22,594	1,495,576	0.015107	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	144,983	12,102,359	0.011980	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	75,371	4,615,975	0.016328	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	171,266	8,016,467	0.021364	0	0	73.00
76.00	03020	SONOGRAPHY	58,149	8,564,131	0.006790	0	0	76.00
76.01	03040	AUDIOLOGY	8,223	505,470	0.016268	0	0	76.01
76.02	03160	CARDIAC REHAB	35,639	1,410,908	0.025260	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
90.00	09000	CLINIC	1,076,327	7,826,306	0.137527	0	0	90.00
91.00	09100	EMERGENCY	331,021	11,246,197	0.029434	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	238,004	4,303,904	0.055300	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	5,262,790	213,472,034		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0143		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part III Date/Time Prepared: 2/26/2020 11:17 am		
					Title XIX		Hospital		PPS		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost				
			1A	1.00	2A	2.00	3.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00		
43.00	04300	NURSERY	0	0	0	0	0	0	43.00		
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	7,486	0.00	501	30.00			
31.00	03100	INTENSIVE CARE UNIT	0	0	752	0.00	13	31.00			
43.00	04300	NURSERY	0	0	577	0.00	197	43.00			
200.00		Total (lines 30 through 199)	0	0	8,815		711	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	
43.00	04300	NURSERY	0							43.00	
200.00		Total (lines 30 through 199)	0							200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Description			Title XIX		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05402	NUCLEAR MEDICINE	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SONOGRAPHY	0	0	0	0	0	76.00
76.01	03040	AUDIOLOGY	0	0	0	0	0	76.01
76.02	03160	CARDIAC REHAB	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/26/2020 11:17 am

				Title XIX		Hospital	PPS		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
			4.00	5.00	6.00	7.00	8.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	39,669,041	0.000000	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,147,099	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	7,618,631	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	18,259,043	0.000000	54.00	
54.01	05402	NUCLEAR MEDICINE	0	0	0	3,306,642	0.000000	54.01	
57.00	05700	CT SCAN	0	0	0	18,836,506	0.000000	57.00	
60.00	06000	LABORATORY	0	0	0	41,852,393	0.000000	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	411,046	0.000000	63.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,949,321	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	10,600,285	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,326,119	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	497,706	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,910,909	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,495,576	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	12,102,359	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,615,975	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,016,467	0.000000	73.00	
76.00	03020	SONOGRAPHY	0	0	0	8,564,131	0.000000	76.00	
76.01	03040	AUDIOLOGY	0	0	0	505,470	0.000000	76.01	
76.02	03160	CARDIAC REHAB	0	0	0	1,410,908	0.000000	76.02	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00	
90.00	09000	CLINIC	0	0	0	7,826,306	0.000000	90.00	
91.00	09100	EMERGENCY	0	0	0	11,246,197	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	4,303,904	0.000000	92.00	
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0.000000	93.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	213,472,034		95.00	
200.00		Total (lines 50 through 199)	0	0	0			200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Description			Title XIX		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	0	0	0	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0 54.00
54.01	05402	NUCLEAR MEDICINE	0.000000	0	0	0	0 54.01
57.00	05700	CT SCAN	0.000000	0	0	0	0 57.00
60.00	06000	LABORATORY	0.000000	0	0	0	0 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0 60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0 63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0 73.00
76.00	03020	SONOGRAPHY	0.000000	0	0	0	0 76.00
76.01	03040	AUDIOLOGY	0.000000	0	0	0	0 76.01
76.02	03160	CARDIAC REHAB	0.000000	0	0	0	0 76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0 88.00
90.00	09000	CLINIC	0.000000	0	0	0	0 90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0 92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0 93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)		0	0	0	0 200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0143	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/26/2020 11:17 am	
		Title XVIII	Hospital	PPS	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			7,488	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			7,486	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			5,289	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)			2	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			3,113	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			224.47	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			231.33	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)			8,602,258	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)			463	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)			463	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			8,601,795	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)			8,601,795	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,149.05	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			3,576,993	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)			3,576,993	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0143

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

Worksheet D-1

Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Description		Title XVIII		Hospital		PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	1,819,377	752	2,419.38	431	1,042,753	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)					5,986,777	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					10,606,523	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)					441,481	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					500,568	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					942,049	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					9,664,474	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)					2,197	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,149.05	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,524,463	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0143

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

Worksheet D-1

Date/Time Prepared:
2/26/2020 11:17 am

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	811,015	8,602,258	0.094279	2,524,463	238,004	90.00
91.00 Nursing School cost	0	8,602,258	0.000000	2,524,463	0	91.00
92.00 Allied health cost	0	8,602,258	0.000000	2,524,463	0	92.00
93.00 All other Medical Education	0	8,602,258	0.000000	2,524,463	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0143

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

Worksheet D-1

Date/Time Prepared:
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Title XIX		Hospital	PPS
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,488	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,486	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,289	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)	2	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)	501	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)	577	15.00
16.00	Nursery days (title V or XIX only)	197	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	224.47	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	231.33	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)	8,602,258	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)	463	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)	463	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,601,795	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)	8,601,795	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY			
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,149.05	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	575,674	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)	575,674	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0143

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

Worksheet D-1

Date/Time Prepared:
2/26/2020 11:17 am

			Title XIX		Hospital	PPS		
Cost Center Description			Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
			1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)		233,553	577	404.77	197	79,740	42.00
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT		1,819,377	752	2,419.38	13	31,452	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)						686,866	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)						76,376	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)						76,376	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						610,490	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)						2,197	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,149.05	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						2,524,463	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0143

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

Worksheet D-1

Date/Time Prepared:
2/26/2020 11:17 am

		Title XIX		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	811,015	8,602,258	0.094279	2,524,463	238,004	90.00
91.00 Nursing School cost	0	8,602,258	0.000000	2,524,463	0	91.00
92.00 Allied health cost	0	8,602,258	0.000000	2,524,463	0	92.00
93.00 All other Medical Education	0	8,602,258	0.000000	2,524,463	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0143	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/26/2020 11:17 am	
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		4,657,100		30.00
31.00	03100	INTENSIVE CARE UNIT		1,151,415		31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.289023	4,539,782	1,312,101	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.712200	291	207	52.00
53.00	05300	ANESTHESIOLOGY	0.069240	1,261,607	87,354	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.225363	1,426,306	321,437	54.00
54.01	05402	NUCLEAR MEDICINE	0.286750	117,397	33,664	54.01
57.00	05700	CT SCAN	0.050065	1,543,763	77,288	57.00
60.00	06000	LABORATORY	0.116252	4,655,155	541,171	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.653416	175,116	114,424	63.00
65.00	06500	RESPIRATORY THERAPY	0.209004	765,208	159,932	65.00
66.00	06600	PHYSICAL THERAPY	0.249553	592,558	147,875	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.204165	80,806	16,498	67.00
68.00	06800	SPEECH PATHOLOGY	0.358326	30,509	10,932	68.00
69.00	06900	ELECTROCARDIOLOGY	0.073002	1,623,935	118,551	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.162285	1,551	252	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.064215	5,980,786	384,056	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.629146	1,740,408	1,094,971	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.483180	1,853,834	895,736	73.00
76.00	03020	SONOGRAPHY	0.102425	604,130	61,878	76.00
76.01	03040	AUDIOLOGY	0.619412	0	0	76.01
76.02	03160	CARDIAC REHAB	0.271700	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	2.473775	50,255	124,320	90.00
91.00	09100	EMERGENCY	0.305815	1,281,931	392,034	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.586552	157,013	92,096	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		28,482,341	5,986,777	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		28,482,341		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0143 Component CCN: 14-U143	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/26/2020 11:17 am	
Cost Center Description			Title XVIII	Swing Beds - SNF	PPS	
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.289023	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.712200	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.069240	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.225363	0	0	54.00
54.01	05402	NUCLEAR MEDICINE	0.286750	0	0	54.01
57.00	05700	CT SCAN	0.050065	0	0	57.00
60.00	06000	LABORATORY	0.116252	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.653416	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.209004	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.249553	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.204165	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.358326	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.073002	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.162285	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.064215	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.629146	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.483180	0	0	73.00
76.00	03020	SONOGRAPHY	0.102425	0	0	76.00
76.01	03040	AUDIOLOGY	0.619412	0	0	76.01
76.02	03160	CARDIAC REHAB	0.271700	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	2.473775	0	0	90.00
91.00	09100	EMERGENCY	0.305815	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.586552	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0143	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part A Date/Time Prepared: 2/26/2020 11:17 am
		Title XVIII	Hospital	PPS
				1.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		6,960,975	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		10,572	2.04
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		37.98	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)		1.00	30.00
31.00	Percentage of Medicaid patient days (see instructions)		13.26	31.00
32.00	Sum of lines 30 and 31		14.26	32.00
33.00	Allowable disproportionate share percentage (see instructions)		0.00	33.00
34.00	Disproportionate share adjustment (see instructions)		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0143	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part A Date/Time Prepared: 2/26/2020 11:17 am	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		0	8,272,863,477	35.00
35.01	Factor 3 (see instructions)	0.000000000	0	0.000035635	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		0		36.00
40.00	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)	6,971,547			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	8,332,518			48.00
			Amount		
			1.00		
49.00	Total payment for inpatient operating costs (see instructions)			7,992,275	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			560,803	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)			8,553,078	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			8,553,078	61.00
62.00	Deductibles billed to program beneficiaries			878,325	62.00
63.00	Coinsurance billed to program beneficiaries			1,729	63.00
64.00	Allowable bad debts (see instructions)			157,953	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			102,669	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			122,466	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			7,775,693	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			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)				70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			779	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			-7,758	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			5,239	70.93
70.94	HRR adjustment amount (see instructions)			-52,162	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0143	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part A Date/Time Prepared: 2/26/2020 11:17 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96	
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97	
70.98	Low Volume Payment-3		0	70.98	
70.99	HAC adjustment amount (see instructions)		84,886	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		7,636,905	71.00	
71.01	Sequestration adjustment (see instructions)		152,738	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
72.00	Interim payments		7,319,842	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)		164,325	74.00	
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		15,350	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)			1,020,728	100.00
	HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)			1.0007632776	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			779	102.00
	HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)			0.9924	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			-7,758	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

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
2/26/2020 11:17 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	0
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	6,960,975	0	0	6,960,975	6,960,975
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	10,572	0	0
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	10,572	0	0	0	0
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0	0
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	0
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
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	0.000000	0
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000	0
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0
11.01	Uncompensated care payments	36.00	0	0	0	0	0
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	6,971,547	0	10,572	6,960,975	6,971,547
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	8,332,518	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	7,992,275	0	10,572	7,981,703	7,992,275

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
2/26/2020 11:17 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	560,803	0	0	560,803	560,803
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0
17.01	Net organ acquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	10,572	8,542,506	8,553,078
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	558,623	0	0	558,623	558,623
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	2,180	0	0	2,180	2,180
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.00000	0.00000	0.00000	0.00000	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.00000	0.00000	0.00000	0.00000	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	560,803	0	0	560,803	560,803
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.000000	0.000000	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5			Provider CCN: 14-0143		Period: From 10/01/2018 To 09/30/2019		Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/26/2020 11:17 am	
			Title XVIII		Hospital		PPS	
			Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
			0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00						1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01		0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02		6,960,975		6,960,975	6,960,975	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						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02		0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03		0	10,572		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04		10,572		0	0	2.03
3.00	Operating outlier reconciliation	2.01		0	0	0	0	3.00
4.00	Managed care simulated payments	3.00		0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00		0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00		0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01		0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00		0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00		0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01		0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00		0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01		0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00		0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00		0	0	0	0	11.00
11.01	Uncompensated care payments	36.00		0	0	0	0	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00		0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00		6,971,547	10,572	6,960,975	6,971,547	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00		8,332,518	0	8,332,518	8,332,518	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00		7,992,275	10,572	7,981,703	7,992,275	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00		560,803	0	560,803	560,803	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				10,572	8,542,506	8,553,078	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
2/26/2020 11:17 am

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	558,623	0	558,623	558,623	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	2,180	0	2,180	2,180	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	560,803	0	560,803	560,803	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	5,239	0	5,239	5,239	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	779	0	779	779	30.01
31.00	HRR adjustment (see instructions)	70.94	-52,162	0	-52,162	-52,162	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	-7,758	0	-7,758	-7,758	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	84,886	84,886	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0143	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part B Date/Time Prepared: 2/26/2020 11:17 am
		Title XVIII	Hospital	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		53,369	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		13,263,029	2.00
3.00	OPPS payments		9,180,286	3.00
4.00	Outlier payment (see instructions)		87,204	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.799	5.00
6.00	Line 2 times line 5		10,597,160	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		87.45	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)		53,369	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		110,455	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)		110,455	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)		110,455	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		57,086	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)		53,369	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)		9,267,490	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)		1,968,933	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)		7,351,926	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)		7,351,926	30.00
31.00	Primary payer payments		982	31.00
32.00	Subtotal (line 30 minus line 31)		7,350,944	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)		242,900	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		157,885	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		187,250	36.00
37.00	Subtotal (see instructions)		7,508,829	37.00
38.00	MSP-LCC reconciliation amount from PS&R		6	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)		7,508,823	40.00
40.01	Sequestration adjustment (see instructions)		150,176	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		7,362,758	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-4,111	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: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet E-1
Part I
Date/Time Prepared:
2/26/2020 11:17 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		7,728,716		7,362,758	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	09/27/2019	408,874		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-408,874		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		7,319,842		7,362,758	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		164,325		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		4,111	6.02
7.00	Total Medicare program liability (see instructions)		7,484,167		7,358,647	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN:14-0143

Period:

Worksheet E-1

Component CCN:14-U143

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/26/2020 11:17 am

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN:14-0143	Period: From 10/01/2018 To 09/30/2019	Worksheet E-1 Part II Date/Time Prepared: 2/26/2020 11:17 am	
		Title XVIII	Hospital	PPS	
				1.00	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14				1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20				6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168				7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)				10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)				32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN:14-0143

Period:

Worksheet E-2

Component CCN:14-U143

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/26/2020 11:17 am

		Title XVIII	Swing Beds - SNF	PPS	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)			0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		0	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		0	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		0	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		0	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		0	0	19.00
19.01	Sequestration adjustment (see instructions)		0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
20.00	Interim payments		0	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		0	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
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 swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

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

Provider CCN: 14-0143

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

Worksheet G

Date/Time Prepared:
2/26/2020 11:17 am

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	1,608,503	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	18,145,027	0	0	0	4.00
5.00 Other receivable	437,997	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-4,122,000	0	0	0	6.00
7.00 Inventory	1,993,877	0	0	0	7.00
8.00 Prepaid expenses	954,764	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)	19,018,168	0	0	0	11.00
FIXED ASSETS					
12.00 Land	2,841,557	0	0	0	12.00
13.00 Land improvements	3,306,546	0	0	0	13.00
14.00 Accumulated depreciation	-2,531,128	0	0	0	14.00
15.00 Buildings	73,501,017	0	0	0	15.00
16.00 Accumulated depreciation	-41,683,979	0	0	0	16.00
17.00 Leasehold improvements	0	0	0	0	17.00
18.00 Accumulated depreciation	0	0	0	0	18.00
19.00 Fixed equipment	0	0	0	0	19.00
20.00 Accumulated depreciation	0	0	0	0	20.00
21.00 Automobiles and trucks	0	0	0	0	21.00
22.00 Accumulated depreciation	0	0	0	0	22.00
23.00 Major movable equipment	33,057,141	0	0	0	23.00
24.00 Accumulated depreciation	-26,369,320	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	291,985	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	42,413,819	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	35,434,317	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	1,606,460	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	37,040,777	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	98,472,764	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	7,277,069	0	0	0	37.00
38.00 Salaries, wages, and fees payable	3,521,960	0	0	0	38.00
39.00 Payroll taxes payable	322,423	0	0	0	39.00
40.00 Notes and loans payable (short term)	5,051,266	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	217,618	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	16,390,336	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	22,743,491	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	2,144,044	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	24,887,535	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	41,277,871	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	57,194,893				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)	57,194,893	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	98,472,764	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0143

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

Worksheet G-1

Date/Time Prepared:
2/26/2020 11:17 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		59,357,210		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,668,673				2.00
3.00	Total (sum of line 1 and line 2)		57,688,537		0		3.00
4.00	CONTRIBUTIONS	84,449		0		0	4.00
5.00	RESTRICTED CONTRIBUTIONS	0		0		0	5.00
6.00	DISTRIBUTIONS	6,655		0		0	6.00
7.00	UNRESTRICTED CONTRIBUTIONS	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)		91,104		0		10.00
11.00	Subtotal (line 3 plus line 10)		57,779,641		0		11.00
12.00	EQUITY TRANSFER	497,392		0		0	12.00
13.00	NET ASSETS RELEASED FROM RESTRICTION	87,359		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)		584,751		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		57,194,890		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	CONTRIBUTIONS		0				4.00
5.00	RESTRICTED CONTRIBUTIONS		0				5.00
6.00	DISTRIBUTIONS		0				6.00
7.00	UNRESTRICTED CONTRIBUTIONS		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	EQUITY TRANSFER		0				12.00
13.00	NET ASSETS RELEASED FROM RESTRICTION		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: 14-0143

Period:
From 10/01/2018
To 09/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	10,736,324		10,736,324	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)	10,736,324		10,736,324	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	4,056,300		4,056,300	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)	4,056,300		4,056,300	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	14,792,624		14,792,624	17.00
18.00	Ancillary services	49,139,583	160,583,671	209,723,254	18.00
19.00	Outpatient services	0	30,241,845	30,241,845	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	768,898	768,898	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	4,126,456	4,126,456	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)	63,932,207	195,720,870	259,653,077	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		90,030,589		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)		90,030,589		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0143

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

Worksheet G-3

Date/Time Prepared:
2/26/2020 11:17 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	259,653,077	1.00
2.00	Less contractual allowances and discounts on patients' accounts	173,938,016	2.00
3.00	Net patient revenues (line 1 minus line 2)	85,715,061	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	90,030,589	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,315,528	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	237,135	14.00
15.00	Revenue from rental of living quarters	61,776	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	263,521	17.00
18.00	Revenue from sale of medical records and abstracts	1,404	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	140,076	22.00
23.00	Governmental appropriations	0	23.00
24.00	LOSS ON DISPOSAL OF EQUIPMENT	5,510	24.00
24.01	EMR REVENUE	51,000	24.01
24.02	NET RENTAL INCOME	25,416	24.02
24.03	OTHER REVENUE	7,196	24.03
24.04	PARATRANSIT	260,398	24.04
24.05	OUTSIDE REHABILITATION SERVICES	1,384	24.05
24.06	CONTRIBUTIONS SPENT FOR OPERATIONS	93,794	24.06
24.07	INVESTMENT INCOME	1,516,775	24.07
25.00	Total other income (sum of lines 6-24)	2,665,385	25.00
26.00	Total (line 5 plus line 25)	-1,650,143	26.00
27.00	NET RENTAL LOSS	0	27.00
27.01	OTHER	0	27.01
27.02	CHANGE IN EQUITY GAINS AND LOSSES	18,368	27.02
27.03	MISCELLANEOUS	162	27.03
27.04	OTHER EXPENSES (SPECIFY)	0	27.04
27.05	OTHER EXPENSES (SPECIFY)	0	27.05
28.00	Total other expenses (sum of line 27 and subscripts)	18,530	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,668,673	29.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0143

Period:

Worksheet 0

Hospice CCN: 14-1595

From 10/01/2018

To 09/30/2019

Date/Time Prepared:

2/26/2020 11:17 am

						Hospice I			
		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI- CATIONS	SUBTOTAL			
		1.00	2.00	3.00	4.00	5.00			
GENERAL SERVICE COST CENTERS									
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00		
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00		
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3.00		
4.00	ADMINISTRATIVE & GENERAL*		49,643	49,643	0	49,643	4.00		
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	5.00		
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00		
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00		
8.00	DIETARY*	0	0	0	0	0	8.00		
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00		
10.00	ROUTINE MEDICAL SUPPLIES*	0	14,321	14,321	0	14,321	10.00		
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00		
12.00	STAFF TRANSPORTATION*	0	26,025	26,025	0	26,025	12.00		
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00		
14.00	PHARMACY*		12,571	12,571	0	12,571	14.00		
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00		
16.00	OTHER GENERAL SERVICE (DELETED)*	0	0	0	0	0	16.00		
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00		
DIRECT PATIENT CARE SERVICE COST CENTERS									
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25.00		
26.00	PHYSICIAN SERVICES**	0	60,000	60,000	0	60,000	26.00		
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00		
28.00	REGISTERED NURSE**	483,716	0	483,716	0	483,716	28.00		
29.00	LPN/LVN**	0	0	0	0	0	29.00		
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00		
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00		
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00		
33.00	MEDICAL SOCIAL SERVICES**	47,947	0	47,947	0	47,947	33.00		
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0	34.00		
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00		
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00		
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	30,507	0	30,507	0	30,507	37.00		
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00		
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00		
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00		
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00		
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0	42.00		
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42.50		
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00		
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00		
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00		
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	660,804	660,804	0	660,804	46.00		
NONREIMBURSABLE COST CENTERS									
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00		
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00		
62.00	FUNDRAISING*	0	0	0	0	0	62.00		
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00		
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00		
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00		
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00		
67.00	ADVERTISING*	0	0	0	0	0	67.00		
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00		
69.00	THRIFT STORE*	0	0	0	0	0	69.00		
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00		
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00		
100.00	TOTAL	562,170	823,364	1,385,534	0	1,385,534	100.00		

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0143

Period:

Worksheet 0

Hospice CCN: 14-1595

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/26/2020 11:17 am

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	Hospice I	
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		3.00
4.00	ADMINISTRATIVE & GENERAL*	0	49,643		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	0		8.00
9.00	NURSING ADMINISTRATION*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	14,321		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	26,025		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0		13.00
14.00	PHARMACY*	0	12,571		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE (DELETED)*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
DIRECT PATIENT CARE SERVICE COST CENTERS					
25.00	INPATIENT CARE-CONTRACTED**	0	0		25.00
26.00	PHYSICIAN SERVICES**	0	60,000		26.00
27.00	NURSE PRACTITIONER**	0	0		27.00
28.00	REGISTERED NURSE**	0	483,716		28.00
29.00	LPN/LVN**	0	0		29.00
30.00	PHYSICAL THERAPY**	0	0		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	47,947		33.00
34.00	SPIRITUAL COUNSELING**	0	0		34.00
35.00	DIETARY COUNSELING**	0	0		35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	30,507		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		38.00
39.00	PATIENT TRANSPORTATION**	0	0		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0		42.50
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	660,804		46.00
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAISING*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESIDENTIAL CARE*	0	0		66.00
67.00	ADVERTISING*	0	0		67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00	TOTAL	0	1,385,534		100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE CONTINUOUS HOME CARE

Provider CCN: 14-0143

Period:

Worksheet 0-1

Hospice CCN: 14-1595

From 10/01/2018

To 09/30/2019

Date/Time Prepared:
2/26/2020 11:17 am

				Hospice I		2/26/2020 11:17 am	
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	0	0	0	0	0	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	0	0	0	0	0	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 50.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	0	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	0	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 50.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE

Provider CCN: 14-0143

Period:

Worksheet 0-2

Hospice CCN: 14-1595

From 10/01/2018

To 09/30/2019

Date/Time Prepared:

2/26/2020 11:17 am

						Hospice I		2/26/2020 11:17 am	
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL			
		1.00	2.00	3.00	4.00	5.00			
DIRECT PATIENT CARE SERVICE COST CENTERS									
25.00	INPATIENT CARE-CONTRACTED							25.00	
26.00	PHYSICIAN SERVICES	0	58,837	58,837	0	58,837		26.00	
27.00	NURSE PRACTITIONER	0	0	0	0	0		27.00	
28.00	REGISTERED NURSE	474,339	0	474,339	0	474,339		28.00	
29.00	LPN/LVN	0	0	0	0	0		29.00	
30.00	PHYSICAL THERAPY	0	0	0	0	0		30.00	
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0		31.00	
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0		32.00	
33.00	MEDICAL SOCIAL SERVICES	47,018	0	47,018	0	47,018		33.00	
34.00	SPIRITUAL COUNSELING	0	0	0	0	0		34.00	
35.00	DIETARY COUNSELING	0	0	0	0	0		35.00	
36.00	COUNSELING - OTHER	0	0	0	0	0		36.00	
37.00	HOSPICE AIDE & HOME MAKER SERVICES	29,915	0	29,915	0	29,915		37.00	
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0		38.00	
39.00	PATIENT TRANSPORTATION	0	0	0	0	0		39.00	
40.00	IMAGING SERVICES	0	0	0	0	0		40.00	
41.00	LABS & DIAGNOSTICS	0	0	0	0	0		41.00	
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0		42.00	
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0		42.50	
43.00	OUTPATIENT SERVICES	0	0	0	0	0		43.00	
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0		44.00	
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0		45.00	
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	647,995	647,995	0	647,995		46.00	
100.00	TOTAL *	551,272	706,832	1,258,104	0	1,258,104		100.00	

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSICIAN SERVICES	0	58,837	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	474,339	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	47,018	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	29,915	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	647,995	46.00
100.00	TOTAL *	0	1,258,104	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT
RESPIRE CARE

Provider CCN: 14-0143

Period:

Worksheet 0-3

Hospice CCN: 14-1595

From 10/01/2018

To 09/30/2019

Date/Time Prepared:
2/26/2020 11:17 am

					Hospice I		2/26/2020 11:17 am	
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL		
		1.00	2.00	3.00	4.00	5.00		
DIRECT PATIENT CARE SERVICE COST CENTERS								
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00	
26.00	PHYSICIAN SERVICES	0	154	154	0	154	26.00	
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00	
28.00	REGISTERED NURSE	1,245	0	1,245	0	1,245	28.00	
29.00	LPN/LVN	0	0	0	0	0	29.00	
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00	
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00	
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00	
33.00	MEDICAL SOCIAL SERVICES	123	0	123	0	123	33.00	
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00	
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00	
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00	
37.00	HOSPICE AIDE & HOME MAKER SERVICES	79	0	79	0	79	37.00	
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00	
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00	
40.00	IMAGING SERVICES	0	0	0	0	0	40.00	
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00	
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00	
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50	
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00	
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00	
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00	
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	1,701	1,701	0	1,701	46.00	
100.00	TOTAL *	1,447	1,855	3,302	0	3,302	100.00	

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	154	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	1,245	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	123	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	79	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	1,701	46.00
100.00	TOTAL *	0	3,302	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL
INPATIENT CARE

Provider CCN: 14-0143

Period:

Worksheet 0-4

Hospice CCN: 14-1595

From 10/01/2018

To 09/30/2019

Date/Time Prepared:
2/26/2020 11:17 am

				Hospice I		2/26/2020 11:17 am	
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	1,009	1,009	0	1,009	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	8,132	0	8,132	0	8,132	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	806	0	806	0	806	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	513	0	513	0	513	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	11,108	11,108	0	11,108	46.00
100.00	TOTAL *	9,451	12,117	21,568	0	21,568	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	1,009	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	8,132	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	806	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	513	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	11,108	46.00
100.00	TOTAL *	0	21,568	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET
EXPENSES FOR ALLOCATION

Provider CCN: 14-0143

Period:

Worksheet 0-5

Hospice CCN: 14-1595

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/26/2020 11:17 am

Descriptions		Hospice I		TOTAL EXPENSES (sum of cols. 1 + 2)	
		HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)		
		1.00	2.00	3.00	
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	9,736	9,736	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	121,762	121,762	3.00
4.00	ADMINISTRATIVE & GENERAL	49,643	355,587	405,230	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	17,822	17,822	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	14,321	0	14,321	10.00
11.00	MEDICAL RECORDS	0	47,112	47,112	11.00
12.00	STAFF TRANSPORTATION	26,025	0	26,025	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	13.00
14.00	PHARMACY	12,571	0	12,571	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	17.00
LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,258,104	0	1,258,104	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	3,302	0	3,302	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	21,568	0	21,568	53.00
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	66.00
67.00	ADVERTISING	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	99.00
100.00	TOTAL	1,385,534	552,019	1,937,553	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:

Worksheet 0-6

Hospice CCN: 14-1595

From 10/01/2018
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Descriptions		TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	Hospice I EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	9,736	9,736				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	121,762	0	0	121,762		3.00
4.00	ADMINISTRATIVE & GENERAL	405,230	9,736	0	0	414,966	4.00
5.00	PLANT OPERATION & MAINTENANCE	17,822	0	0	0	17,822	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	14,321	0	0	0	14,321	10.00
11.00	MEDICAL RECORDS	47,112	0	0	0	47,112	11.00
12.00	STAFF TRANSPORTATION	26,025	0	0	0	26,025	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	12,571	0	0	0	12,571	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,258,104			119,700	1,377,804	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	3,302	0	0	101	3,403	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	21,568	0	0	1,961	23,529	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	1,937,553	9,736	0	121,762	1,937,553	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:

Worksheet 0-6

Hospice CCN: 14-1595

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Descriptions		Hospice I		DIETARY	
		ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	
		4.00	5.00	6.00	7.00
					8.00
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT				1.00
2.00	CAP REL COSTS-MVBLE EQUIP				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT				3.00
4.00	ADMINISTRATIVE & GENERAL	414,966			4.00
5.00	PLANT OPERATION & MAINTENANCE	4,857	22,679		5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	3,903	0	0	10.00
11.00	MEDICAL RECORDS	12,840	0	0	11.00
12.00	STAFF TRANSPORTATION	7,093	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	13.00
14.00	PHARMACY	3,426	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	17.00
LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	375,507			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	927	4,005	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	6,413	18,674	0	53.00
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	66.00
67.00	ADVERTISING	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	99.00
100.00	TOTAL	414,966	22,679	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0143

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Descriptions		Hospice I					
		NURSING ADMINISTRATIO N	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATIO N	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	18,224				10.00
11.00	MEDICAL RECORDS	0		59,952			11.00
12.00	STAFF TRANSPORTATION	0			33,118		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	17,871	58,790	33,118	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	47	154	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	306	1,008	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	18,224	59,952	33,118	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:

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Descriptions		Hospice I				TOTAL	
		PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE (DELETED)	PATIENT/ RESIDENTIAL CARE SERVICES		
		14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	15,997					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	15,735	0	0		1,878,825	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	2	0	0	0	8,538	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	260	0	0	0	50,190	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	15,997	0	0	0	1,937,553	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0143

Period:

Worksheet 0-6

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Cost Center Descriptions		CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATIO N	ADMINISTRATIV E & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	974					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	557,301			3.00
4.00	ADMINISTRATIVE & GENERAL	974	0	0	-414,966	1,522,587	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	17,822	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	14,321	10.00
11.00	MEDICAL RECORDS	0	0	0	0	47,112	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	26,025	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	12,571	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			547,863	0	1,377,804	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	463	0	3,403	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	8,975	0	23,529	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	9,736	0	121,762		414,966	100.00
101.00	UNIT COST MULTIPLIER	9.995893	0.000000	0.218485		0.272540	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0143

Period:

Worksheet 0-6

Hospice CCN: 14-1595

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Cost Center Descriptions		Hospice I					
		PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATIO N (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	974					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		0			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0		0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	172	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	802	0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	22,679	0	0	0	0	100.00
101.00	UNIT COST MULTIPLIER	23.284394	0.000000	0.000000	0.000000	0.000000	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0143

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Cost Center Descriptions		Hospice I					
		ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	6,603					10.00
11.00	MEDICAL RECORDS		6,603				11.00
12.00	STAFF TRANSPORTATION			100			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	7,864	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	6,475	6,475	100	0	7,735	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	17	17	0	0	1	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	111	111	0	0	128	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD			0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	18,224	59,952	33,118	0	15,997	100.00
101.00	UNIT COST MULTIPLIER	2.759958	9.079509	331.180000	0.000000	2.034207	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0143

Period:

Worksheet 0-6

Hospice CCN: 14-1595

From 10/01/2018
To 09/30/2019Part II
Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Descriptions		PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (DELETED) (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)	Hospice I	
		15.00	16.00	17.00		
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15.00
16.00	OTHER GENERAL SERVICE (DELETED)		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0		53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY
LEVEL OF CARE

Provider CCN: 14-0143

Period:

Worksheet 0-7

Hospice CCN: 14-1595

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

Date/Time Prepared:
2/26/2020 11:17 am

Cost Center Descriptions		From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records)			
				HCHC	HRHC	HIRC	
				0	1.00	2.00	
1.00	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.249553	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.204165	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.358326	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.483180	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.116252	0	0	0	6.00
6.01	BLOOD LABORATORY	60.01	0.000000	0	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.064215	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00	0.000000	0	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	SONOGRAPHY	76.00	0.102425	0	0	0	10.00
10.01	AUDIOLOGY	76.01	0.619412	0	0	0	10.01
10.02	CARDIAC REHAB	76.02	0.271700	0	0	0	10.02
11.00	Totals (sum of lines 1-11)						11.00
Cost Center Descriptions		Charges by LOC (from Provider Records)	Shared Service Costs by LOC				
		HGIP	HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
ANCILLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	0	0	0	0	0	2.00
3.00	SPEECH PATHOLOGY	0	0	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
6.01	BLOOD LABORATORY	0	0	0	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	SONOGRAPHY	0	0	0	0	0	10.00
10.01	AUDIOLOGY	0	0	0	0	0	10.01
10.02	CARDIAC REHAB	0	0	0	0	0	10.02
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 14-0143

Period:

Worksheet 0-8

Hospice CCN: 14-1595

From 10/01/2018

To 09/30/2019

Date/Time Prepared:

2/26/2020 11:17 am

		Hospice I			
		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
HOSPICE ROUTINE HOME CARE					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11)			1,878,825	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			6,475	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			290.17	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	6,475	0		9.00
10.00	Program cost (line 8 times line 9)	1,878,851	0		10.00
HOSPICE INPATIENT RESPITE CARE					
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11)			8,538	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			17	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			502.24	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	17	0		14.00
15.00	Program cost (line 13 times line 14)	8,538	0		15.00
HOSPICE GENERAL INPATIENT CARE					
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11)			50,190	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			111	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			452.16	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	111	0		19.00
20.00	Program cost (line 18 times line 19)	50,190	0		20.00
TOTAL HOSPICE CARE					
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			1,937,553	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			6,603	22.00
23.00	Average cost per diem (line 21 divided by line 22)			293.44	23.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0143	Period: From 10/01/2018 To 09/30/2019	Worksheet L Parts I-III Date/Time Prepared: 2/26/2020 11:17 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		558,623	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		2,180	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		16.93	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		560,803	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