

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

FORM APPROVED

OMB NO. 0938-0050

EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0177	Period: From 04/01/2018 To 03/31/2019	Worksheet S Parts I-III Date/Time Prepared: 8/24/2019 9:31 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 8/24/2019	Time: 9:31 am
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by JACKSON PARK HOSPITAL (14-0177) for the cost reporting period beginning 04/01/2018 and ending 03/31/2019 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	501,789	-24,315	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	501,789	-24,315	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0177		Period: From 04/01/2018 To 03/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/24/2019 9:31 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 7531 SOUTH STONEY ISLAND AVENUE			PO Box:				1.00	
2.00	City: CHICAGO			State: IL		Zip Code: 60649		County: COOK	
		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
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			JACKSON PARK HOSPITAL	140177	16974	1	07/01/1966	N
4.00	Subprovider - IPF							P	O
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						04/01/2018	03/31/2019	
21.00	Type of Control (see instructions)						2		
							1.00	2.00	
							2.00	3.00	
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			1,819	687	0	21	12,025	256

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019Worksheet S-2
Part I
Date/Time Prepared:
8/24/2019 9:31 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019Worksheet S-2
Part I
Date/Time Prepared:
8/24/2019 9:31 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019Worksheet S-2
Part I
Date/Time Prepared:
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			1.00	2.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
			1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS					
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0
	Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0177	Period: From 04/01/2018 To 03/31/2019	Worksheet S-2 Part I Date/Time Prepared: 8/24/2019 9:31 am	
			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.	N	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.	N	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				109.00
			1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N		110.00	

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			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
			1.00	2.00	3.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1,315,627	0	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N			140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0177		Period: From 04/01/2018 To 03/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/24/2019 9:31 am	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	Contractor's Name:			Contractor's Number:			141.00	
142.00	Street:	PO Box:						142.00	
143.00	City:	State:			Zip Code:			143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				Y				145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N				146.00
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	161.00		
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							9.99	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					04/01/2018	03/31/2019		170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N	0		171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0177	Period: From 04/01/2018 To 03/31/2019	Worksheet S-2 Part II Date/Time Prepared: 8/24/2019 9:31 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)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	07/30/2019	Y 07/30/2019
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019Worksheet S-2
Part II
Date/Time Prepared:
8/24/2019 9:31 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				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.	RAJ	SHAH		41.00
42.00	Enter the employer/company name of the cost report preparer.	STRATEGIC REIMBURSEMENT GROUP, LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	630-530-7100 X 107	RAJ.SHAH@SRGROUPLLC.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019Worksheet S-2
Part II
Date/Time Prepared:
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		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER		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: 14-0177

Period:
From 04/01/2018
To 03/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/24/2019 9:31 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	193	70,445	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)		193	70,445	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,920	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)		201	73,365	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		201			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/24/2019 9:31 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)	6,221	2,721	24,625			1.00
2.00	HMO and other (see instructions)	630	12,025				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	6,221	2,721	24,625			7.00
8.00	INTENSIVE CARE UNIT	493	0	1,790			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		48	48			13.00
14.00	Total (see instructions)	6,714	2,769	26,463	17.92	616.77	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			97			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				17.92	616.77	27.00
28.00	Observation Bed Days		288	2,042			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	14	18			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: 14-0177

Period:
From 04/01/2018
To 03/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/24/2019 9:31 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,304	651	6,093	1.00
2.00 HMO and other (see instructions)			143	2,863		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,304	651	6,093	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019Worksheet S-3
Part II
Date/Time Prepared:
8/24/2019 9:31 am

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	37,992,202	0	37,992,202	1,282,879.00	29.61
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	1,027,096	0	1,027,096	39,618.00	25.92
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		3,401,869	0	3,401,869	65,873.00	51.64
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		3,991,094	0	3,991,094	54,419.00	73.34
12.00	Contract labor: Top level management and other management and administrative services		171,310	0	171,310	1,784.00	96.03
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		6,892,921	0	6,892,921		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		385,648	0	385,648		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		231,940	0	231,940		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	134,222	0	134,222	7,667.00	17.51
27.00	Administrative & General	5.00	7,660,607	0	7,660,607	191,361.00	40.03

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019Worksheet S-3
Part II
Date/Time Prepared:
8/24/2019 9:31 am

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		60,200	0	60,200	301.00	200.00	28.00
29.00	Maintenance & Repairs	6.00	566,920	0	566,920	15,881.00	35.70	29.00
30.00	Operation of Plant	7.00	593,560	0	593,560	29,276.00	20.27	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,018,071	0	1,018,071	67,883.00	15.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	873,421	-344,639	528,782	31,567.00	16.75	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	344,639	344,639	20,800.00	16.57	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,086,612	0	1,086,612	35,993.00	30.19	38.00
39.00	Central Services and Supply	14.00	31,511	0	31,511	2,340.00	13.47	39.00
40.00	Pharmacy	15.00	824,815	0	824,815	21,047.00	39.19	40.00
41.00	Medical Records & Medical Records Library	16.00	640,122	0	640,122	34,396.00	18.61	41.00
42.00	Social Service	17.00	115,244	0	115,244	5,909.00	19.50	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019Worksheet S-3
Part III
Date/Time Prepared:
8/24/2019 9:31 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	37,025,306	0	37,025,306	1,243,562.00	29.77	1.00
2.00	Excluded area salaries (see instructions)	3,401,869	0	3,401,869	65,873.00	51.64	2.00
3.00	Subtotal salaries (line 1 minus line 2)	33,623,437	0	33,623,437	1,177,689.00	28.55	3.00
4.00	Subtotal other wages & related costs (see inst.)	4,162,404	0	4,162,404	56,203.00	74.06	4.00
5.00	Subtotal wage-related costs (see inst.)	6,892,921	0	6,892,921	0.00	20.50	5.00
6.00	Total (sum of lines 3 thru 5)	44,678,762	0	44,678,762	1,233,892.00	36.21	6.00
7.00	Total overhead cost (see instructions)	13,605,305	0	13,605,305	464,421.00	29.30	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019Worksheet S-3
Part IV
Date/Time Prepared:
8/24/2019 9:31 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	1,058,063	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)	2,956,218	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	124,762	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	629,459	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	2,672,576	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	65,281	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	4,150	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	7,510,509	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019Worksheet S-3
Part V
Date/Time Prepared:
8/24/2019 9:31 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	3,991,094	7,510,509	1.00
2.00	Hospital	3,991,094	7,510,509	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0177	Period: From 04/01/2018 To 03/31/2019	Worksheet S-10 Date/Time Prepared: 8/24/2019 9:31 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)		0.283503	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		41,033,034	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		98,353,230	6.00	
7.00	Medicaid cost (line 1 times line 6)		27,883,436	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		0	9.00	
10.00	Stand-alone CHIP charges		0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00	
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	10,055,430	39,255	10,094,685	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,850,745	39,255	2,890,000	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,850,745	39,255	2,890,000	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)		7,044,567	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		539,593	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		830,143	27.01	
28.00	Non-Medicare bad debt expense (see instructions)		6,214,424	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		2,052,358	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		4,942,358	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		4,942,358	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019

Worksheet A

Date/Time Prepared:
8/24/2019 9:31 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0	3,128,876	3,128,876	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	134,222	92,017	226,239	7,369,641	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,660,607	24,338,977	31,999,584	-10,327,207	5.00
6.00	00600	MAINTENANCE & REPAIRS	566,920	310,830	877,750	0	6.00
7.00	00700	OPERATION OF PLANT	593,560	1,942,561	2,536,121	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	148,615	148,615	0	8.00
9.00	00900	HOUSEKEEPING	1,018,071	533,933	1,552,004	0	9.00
10.00	01000	DIETARY	873,421	655,991	1,529,412	-351,053	10.00
11.00	01100	CAFETERIA	0	105,675	105,675	351,053	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	145,678	145,678	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,086,612	222,317	1,308,929	-171,310	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	31,511	39,839	71,350	0	14.00
15.00	01500	PHARMACY	824,815	1,435,146	2,259,961	-1,395,995	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	640,122	196,420	836,542	0	16.00
17.00	01700	SOCIAL SERVICE	115,244	-4	115,240	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,027,096	93,610	1,120,706	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	2,320	2,320	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	10,712,965	1,565,954	12,278,919	-47,933	30.00
31.00	03100	INTENSIVE CARE UNIT	1,233,355	2,251,428	3,484,783	0	31.00
43.00	04300	NURSERY	571,415	385,463	956,878	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	894,334	602,770	1,497,104	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,330,993	58,439	1,389,432	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	923,710	1,221,149	2,144,859	0	54.00
55.01	03190	CHEMO THERAPY	0	0	0	47,933	55.01
56.00	05600	RADIOISOTOPE	161,323	33,047	194,370	0	56.00
57.00	05700	CT SCAN	296,303	67,289	363,592	0	57.00
60.00	06000	LABORATORY	0	3,522,141	3,522,141	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	876,832	162,017	1,038,849	0	65.00
66.00	06600	PHYSICAL THERAPY	304,295	132,948	437,243	0	66.00
69.00	06900	ELECTROCARDIOLOGY	245,598	3,241	248,839	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,395,995	73.00
74.00	07400	RENAL DIALYSIS	0	314,239	314,239	0	74.00
76.00	03550	OP PSYCH	155,455	1,527	156,982	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	2,311,554	2,882,363	5,193,917	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
93.01	04950	CANCER CENTER	0	0	0	0	93.01
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,590,333	43,467,940	78,058,273	0	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,311,948	751,146	4,063,094	0	192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER	89,921	110,683	200,604	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	37,992,202	44,329,769	82,321,971	0	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019

Worksheet A

Date/Time Prepared:
8/24/2019 9:31 am

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-209,065	2,919,811	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-195	7,595,685	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-7,579,500	14,092,877	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	877,750	6.00
7.00	00700	OPERATION OF PLANT	-556,201	1,979,920	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	148,615	8.00
9.00	00900	HOUSEKEEPING	0	1,552,004	9.00
10.00	01000	DIETARY	0	1,178,359	10.00
11.00	01100	CAFETERIA	-258,834	197,894	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	145,678	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,137,619	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	71,350	14.00
15.00	01500	PHARMACY	0	863,966	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,213	831,329	16.00
17.00	01700	SOCIAL SERVICE	0	115,240	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	1,120,706	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	2,320	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-508,763	11,722,223	30.00
31.00	03100	INTENSIVE CARE UNIT	-39,583	3,445,200	31.00
43.00	04300	NURSERY	-379,166	577,712	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,497,104	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,389,432	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-975,000	1,169,859	54.00
55.01	03190	CHEMO THERAPY	0	47,933	55.01
56.00	05600	RADIOISOTOPE	0	194,370	56.00
57.00	05700	CT SCAN	0	363,592	57.00
60.00	06000	LABORATORY	0	3,522,141	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	-25,000	1,013,849	65.00
66.00	06600	PHYSICAL THERAPY	0	437,243	66.00
69.00	06900	ELECTROCARDIOLOGY	0	248,839	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,395,995	73.00
74.00	07400	RENAL DIALYSIS	0	314,239	74.00
76.00	03550	OP PSYCH	0	156,982	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-1,543,500	3,650,417	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.01	04950	CANCER CENTER	0	0	93.01
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-12,080,020	65,978,253	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,063,094	192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER	0	200,604	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-12,080,020	70,241,951	200.00

RECLASSIFICATIONS

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019

Worksheet A-6

Date/Time Prepared:
8/24/2019 9:31 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
1.00	A - DEPRECIATION EXPENSE					1.00
	CAP REL COSTS-BLDG & FIXT	1.00	0	2,483,507		
			0	2,483,507		
1.00	B - FRINGE BENEFITS					1.00
	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7,369,641		
			0	7,369,641		
1.00	C - INTEREST					1.00
	CAP REL COSTS-BLDG & FIXT	1.00	0	519,673		
			0	519,673		
1.00	D - CAFETERIA					1.00
	CAFETERIA	11.00	344,639	6,414		
			344,639	6,414		
1.00	F - CHARGEABLE DRUGS					1.00
	DRUGS CHARGED TO PATIENTS	73.00	0	1,395,995		
			0	1,395,995		
1.00	G - CHEMO THERAPY					1.00
	CHEMO THERAPY	55.01	42,254	5,679		
			42,254	5,679		
1.00	H - CAPITAL INSURANCE					1.00
	CAP REL COSTS-BLDG & FIXT	1.00	0	125,696		
			0	125,696		
1.00	I - SVP-CONT LABOR					1.00
	ADMINISTRATIVE & GENERAL	5.00	0	171,310		
	TOTALS		0	171,310		
500.00	Grand Total: Increases			386,893	12,077,915	500.00

RECLASSIFICATIONS

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019

Worksheet A-6

Date/Time Prepared:
8/24/2019 9:31 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	A - DEPRECIATION EXPENSE						1.00
	ADMINISTRATIVE & GENERAL	5.00	0	2,483,507	9		
	0		0	2,483,507			
1.00	B - FRINGE BENEFITS						1.00
	ADMINISTRATIVE & GENERAL	5.00	0	7,369,641	0		
	0		0	7,369,641			
1.00	C - INTEREST						1.00
	ADMINISTRATIVE & GENERAL	5.00	0	519,673	11		
	0		0	519,673			
1.00	D - CAFETERIA						1.00
	DIETARY	10.00	344,639	6,414	0		
	0		344,639	6,414			
1.00	F - CHARGEABLE DRUGS						1.00
	PHARMACY	15.00	0	1,395,995	0		
	0		0	1,395,995			
1.00	G - CHEMO THERAPY						1.00
	ADULTS & PEDIATRICS	30.00	42,254	5,679	0		
	0		42,254	5,679			
1.00	H - CAPITAL INSURANCE						1.00
	ADMINISTRATIVE & GENERAL	5.00	0	125,696	12		
	0		0	125,696			
1.00	I - SVP-CONT LABOR						1.00
	NURSING ADMINISTRATION	13.00	0	171,310	0		
	TOTALS		0	171,310			
500.00	Grand Total: Decreases			386,893	12,077,915		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019Worksheet A-7
Part I
Date/Time Prepared:
8/24/2019 9:31 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	2,482,024	0	0	0	0	1.00	
2.00	Land Improvements	629,240	0	0	0	1,200	2.00	
3.00	Buildings and Fixtures	40,302,116	12,214	0	12,214	0	3.00	
4.00	Building Improvements	13,649,618	3,959,587	0	3,959,587	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	33,214,182	1,807,832	0	1,807,832	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	90,277,180	5,779,633	0	5,779,633	1,200	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	90,277,180	5,779,633	0	5,779,633	1,200	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	2,482,024	0					1.00
2.00	Land Improvements	628,040	0					2.00
3.00	Buildings and Fixtures	40,314,330	0					3.00
4.00	Building Improvements	17,609,205	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	35,022,014	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	96,055,613	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	96,055,613	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019Worksheet A-7
Part II
Date/Time Prepared:
8/24/2019 9:31 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
		PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2					
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019Worksheet A-7
Part III
Date/Time Prepared:
8/24/2019 9:31 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	58,551,576	0	58,551,576	0.625728	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	35,022,014	0	35,022,014	0.374272	0	2.00
3.00	Total (sum of lines 1-2)	93,573,590	0	93,573,590	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,483,507	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,483,507	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	310,608	125,696	0	0	2,919,811	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	310,608	125,696	0	0	2,919,811	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019

Worksheet A-8

Date/Time Prepared:
8/24/2019 9:31 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		A	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-209,065	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-42,720	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-8,951	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,471,012			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-258,834	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others	B	-182,891	OPERATION OF PLANT	7.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-5,213	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019

Worksheet A-8

Date/Time Prepared:
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Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
36.03	LOCKER & ID REVENUE	B	-195	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36.03
36.05	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	36.05
36.06	DIALYSIS RENT	B	-219,719	OPERATION OF PLANT	7.00	9	36.06
36.20	DOCTOR'S OFFICE RENTALS	B	-153,591	OPERATION OF PLANT	7.00	9	36.20
37.00	LOBBYING DUES	A	-38,056	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	38.00
40.00	PROVIDER TAX PROCEEDS	B	-7,348,242	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	MISC REV	B	-141,531	ADMINISTRATIVE & GENERAL	5.00	0	41.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-12,080,020				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019

Worksheet A-8-2

Date/Time Prepared:
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	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	508,763	508,763	0	0	0	1.00
2.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	39,583	39,583	0	0	0	2.00
3.00	43.00	AGGREGATE-NURSERY	379,166	379,166	0	0	0	3.00
4.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	975,000	975,000	0	0	0	4.00
5.00	65.00	AGGREGATE-RESPIRATORY THERAPY	25,000	25,000	0	0	0	5.00
6.00	91.00	EMERGENCY	1,543,500	1,543,500	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,471,012	3,471,012	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	43.00	AGGREGATE-NURSERY	0	0	0	0	0	3.00
4.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	508,763		1.00
2.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	39,583		2.00
3.00	43.00	AGGREGATE-NURSERY	0	0	0	379,166		3.00
4.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	975,000		4.00
5.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	25,000		5.00
6.00	91.00	EMERGENCY	0	0	0	1,543,500		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	3,471,012		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019Worksheet B
Part I
Date/Time Prepared:
8/24/2019 9:31 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,919,811	2,919,811			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0		0		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,595,685	13,020	0	7,608,705	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,092,877	161,310	0	1,539,629	15,793,816
6.00	00600	MAINTENANCE & REPAIRS	877,750	31,192	0	113,940	1,022,882
7.00	00700	OPERATION OF PLANT	1,979,920	694,766	0	119,294	2,793,980
8.00	00800	LAUNDRY & LINEN SERVICE	148,615	11,405	0	0	160,020
9.00	00900	HOUSEKEEPING	1,552,004	37,398	0	204,612	1,794,014
10.00	01000	DIETARY	1,178,359	42,416	0	106,275	1,327,050
11.00	01100	CAFETERIA	197,894	29,652	0	69,266	296,812
12.00	01200	MAINTENANCE OF PERSONNEL	145,678	34,784	0	0	180,462
13.00	01300	NURSING ADMINISTRATION	1,137,619	18,257	0	218,387	1,374,263
14.00	01400	CENTRAL SERVICES & SUPPLY	71,350	42,330	0	6,333	120,013
15.00	01500	PHARMACY	863,966	17,373	0	165,771	1,047,110
16.00	01600	MEDICAL RECORDS & LIBRARY	831,329	42,929	0	128,652	1,002,910
17.00	01700	SOCIAL SERVICE	115,240	14,189	0	23,162	152,591
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,120,706	0	0	206,426	1,327,132
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,320	6,624	0	0	8,944
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	11,722,223	694,413	0	2,144,607	14,561,243
31.00	03100	INTENSIVE CARE UNIT	3,445,200	30,317	0	247,880	3,723,397
43.00	04300	NURSERY	577,712	11,063	0	114,843	703,618
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,497,104	127,115	0	179,743	1,803,962
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,389,432	13,267	0	267,503	1,670,202
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,169,859	93,557	0	185,647	1,449,063
55.01	03190	CHEMO THERAPY	47,933	0	0	8,492	56,425
56.00	05600	RADIOISOTOPE	194,370	15,843	0	32,423	242,636
57.00	05700	CT SCAN	363,592	6,681	0	59,551	429,824
60.00	06000	LABORATORY	3,522,141	34,889	0	0	3,557,030
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	1,013,849	27,295	0	176,226	1,217,370
66.00	06600	PHYSICAL THERAPY	437,243	36,685	0	61,157	535,085
69.00	06900	ELECTROCARDIOLOGY	248,839	0	0	49,360	298,199
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,395,995	0	0	0	1,395,995
74.00	07400	RENAL DIALYSIS	314,239	91,656	0	0	405,895
76.00	03550	OP PSYCH	156,982	20,633	0	31,243	208,858
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	3,650,417	57,299	0	464,576	4,172,292
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
93.01	04950	CANCER CENTER	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	65,978,253	2,458,358	0	6,924,998	64,833,093
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,063,094	461,453	0	665,635	5,190,182
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER	200,604	0	0	18,072	218,676
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	70,241,951	2,919,811	0	7,608,705	70,241,951

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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,793,816					5.00
6.00	00600	MAINTENANCE & REPAIRS	296,708	1,319,590				6.00
7.00	00700	OPERATION OF PLANT	810,453	337,768	3,942,201			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	46,417	5,545	22,262	234,244		8.00
9.00	00900	HOUSEKEEPING	520,391	18,182	73,002	0	2,405,589	9.00
10.00	01000	DIETARY	384,939	20,621	82,798	0	51,776	10.00
11.00	01100	CAFETERIA	86,097	14,416	57,882	0	36,195	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	52,347	16,911	67,901	0	42,460	12.00
13.00	01300	NURSING ADMINISTRATION	398,634	8,876	35,639	0	22,286	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	34,812	20,580	82,631	0	51,671	14.00
15.00	01500	PHARMACY	303,736	8,446	33,913	0	21,207	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	290,915	20,871	83,800	0	52,402	16.00
17.00	01700	SOCIAL SERVICE	44,262	6,898	27,698	0	17,320	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	384,963	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,594	3,220	12,931	0	8,086	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,223,786	337,599	1,355,523	217,988	847,645	30.00
31.00	03100	INTENSIVE CARE UNIT	1,080,049	14,739	59,181	15,831	37,007	31.00
43.00	04300	NURSERY	204,099	5,378	21,595	425	13,504	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	523,277	61,799	248,134	0	155,164	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	484,477	6,450	25,899	0	16,195	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	420,331	45,484	182,626	0	114,201	54.00
55.01	03190	CHEMO THERAPY	16,367	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	70,382	7,702	30,926	0	19,339	56.00
57.00	05700	CT SCAN	124,679	3,248	13,042	0	8,156	57.00
60.00	06000	LABORATORY	1,031,791	16,962	68,105	0	42,588	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	353,124	13,270	53,282	0	33,318	65.00
66.00	06600	PHYSICAL THERAPY	155,213	17,835	71,611	0	44,780	66.00
69.00	06900	ELECTROCARDIOLOGY	86,499	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	404,938	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	117,738	44,560	178,916	0	111,881	74.00
76.00	03550	OP PSYCH	60,584	10,031	40,277	0	25,186	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	1,210,261	27,857	111,850	0	69,943	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.01	04950	CANCER CENTER	0	0	0	0	0	93.01
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,224,863	1,095,248	3,041,424	234,244	1,842,310	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,505,521	224,342	900,777	0	563,279	192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER	63,432	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	15,793,816	1,319,590	3,942,201	234,244	2,405,589	202.00

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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,867,184					10.00
11.00	01100	CAFETERIA	0	491,402				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	360,081			12.00
13.00	01300	NURSING ADMINISTRATION	0	19,253	67,940	1,926,891		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,258	0	0	310,965	14.00
15.00	01500	PHARMACY	0	11,262	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	18,407	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	3,161	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	21,200	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,800,191	222,709	224,201	1,292,949	0	30.00
31.00	03100	INTENSIVE CARE UNIT	66,993	20,677	0	120,043	0	31.00
43.00	04300	NURSERY	0	6,265	67,940	36,375	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	14,913	0	86,576	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	17,839	0	103,568	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,335	0	0	0	54.00
55.01	03190	CHEMO THERAPY	0	1,146	0	0	0	55.01
56.00	05600	RADIOISOTOPE	0	2,081	0	0	0	56.00
57.00	05700	CT SCAN	0	5,409	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	15,369	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,895	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,328	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	310,965	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	OP PSYCH	0	3,149	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	49,501	0	287,380	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.01	04950	CANCER CENTER	0	0	0	0	0	93.01
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,867,184	456,157	360,081	1,926,891	310,965	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	31,706	0	0	0	192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER	0	3,539	0	0	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,867,184	491,402	360,081	1,926,891	310,965	202.00

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	1,425,674					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,469,305				16.00
17.00	01700	SOCIAL SERVICE	0	0	251,930			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	23,990	1,367,338	234,446	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,844	99,304	17,027	0	0	31.00
43.00	04300	NURSERY	0	2,663	457	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,187	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12	0	0	0	0	54.00
55.01	03190	CHEMO THERAPY	0	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	65	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,392,776	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	OP PSYCH	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	1,800	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.01	04950	CANCER CENTER	0	0	0	0	0	93.01
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,425,674	1,469,305	251,930	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,425,674	1,469,305	251,930	0	0	202.00

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,733,295					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		35,775				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,345,426	27,768	0	28,082,802	-1,373,194	30.00
31.00	03100	INTENSIVE CARE UNIT	56,817	1,173	0	5,317,082	-57,990	31.00
43.00	04300	NURSERY	58,332	1,204	0	1,121,855	-59,536	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	115,149	2,377	0	3,013,538	-117,526	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,324,630	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,181	376	0	2,245,609	-18,557	54.00
55.01	03190	CHEMO THERAPY	0	0	0	73,938	0	55.01
56.00	05600	RADIOISOTOPE	0	0	0	373,066	0	56.00
57.00	05700	CT SCAN	0	0	0	584,358	0	57.00
60.00	06000	LABORATORY	0	0	0	4,716,476	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	81,058	1,673	0	1,768,529	-82,731	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	828,419	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	388,026	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	310,965	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	3,193,709	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	858,990	0	74.00
76.00	03550	OP PSYCH	0	0	0	348,085	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	58,332	1,204	0	5,990,420	-59,536	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.01	04950	CANCER CENTER	0	0	0	0	0	93.01
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,733,295	35,775	0	61,540,497	-1,769,070	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	8,415,807	0	192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER	0	0	0	285,647	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,733,295	35,775	0	70,241,951	-1,769,070	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.01	03190	CHEMO THERAPY	55.01
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03550	OP PSYCH	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
93.01	04950	CANCER CENTER	93.01
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019Worksheet B
Part II
Date/Time Prepared:
8/24/2019 9:31 am

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	13,020	0	13,020	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	161,310	0	161,310	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	31,192	0	31,192	6.00
7.00	00700	OPERATION OF PLANT	0	694,766	0	694,766	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	11,405	0	11,405	8.00
9.00	00900	HOUSEKEEPING	0	37,398	0	37,398	9.00
10.00	01000	DIETARY	0	42,416	0	42,416	10.00
11.00	01100	CAFETERIA	0	29,652	0	29,652	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	34,784	0	34,784	12.00
13.00	01300	NURSING ADMINISTRATION	0	18,257	0	18,257	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	42,330	0	42,330	14.00
15.00	01500	PHARMACY	0	17,373	0	17,373	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	42,929	0	42,929	16.00
17.00	01700	SOCIAL SERVICE	0	14,189	0	14,189	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	6,624	0	6,624	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	694,413	0	694,413	30.00
31.00	03100	INTENSIVE CARE UNIT	0	30,317	0	30,317	31.00
43.00	04300	NURSERY	0	11,063	0	11,063	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	127,115	0	127,115	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	13,267	0	13,267	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	93,557	0	93,557	54.00
55.01	03190	CHEMO THERAPY	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	0	15,843	0	15,843	56.00
57.00	05700	CT SCAN	0	6,681	0	6,681	57.00
60.00	06000	LABORATORY	0	34,889	0	34,889	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	27,295	0	27,295	65.00
66.00	06600	PHYSICAL THERAPY	0	36,685	0	36,685	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	91,656	0	91,656	74.00
76.00	03550	OP PSYCH	0	20,633	0	20,633	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	57,299	0	57,299	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
93.01	04950	CANCER CENTER	0	0	0	0	93.01
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,458,358	0	2,458,358	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	461,453	0	461,453	192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,919,811	0	2,919,811	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019Worksheet B
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	163,945					5.00
6.00	00600	MAINTENANCE & REPAIRS	3,080	34,467				6.00
7.00	00700	OPERATION OF PLANT	8,413	8,820	712,203			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	482	145	4,022	16,054		8.00
9.00	00900	HOUSEKEEPING	5,402	475	13,189	0	56,814	9.00
10.00	01000	DIETARY	3,996	539	14,958	0	1,223	10.00
11.00	01100	CAFETERIA	894	377	10,457	0	855	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	543	442	12,267	0	1,003	12.00
13.00	01300	NURSING ADMINISTRATION	4,138	232	6,438	0	526	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	361	538	14,928	0	1,220	14.00
15.00	01500	PHARMACY	3,153	221	6,127	0	501	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,020	545	15,139	0	1,238	16.00
17.00	01700	SOCIAL SERVICE	459	180	5,004	0	409	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	3,996	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	27	84	2,336	0	191	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	43,844	8,818	244,893	14,940	20,018	30.00
31.00	03100	INTENSIVE CARE UNIT	11,211	385	10,692	1,085	874	31.00
43.00	04300	NURSERY	2,119	140	3,901	29	319	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,432	1,614	44,828	0	3,665	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,029	168	4,679	0	382	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,363	1,188	32,994	0	2,697	54.00
55.01	03190	CHEMO THERAPY	170	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	731	201	5,587	0	457	56.00
57.00	05700	CT SCAN	1,294	85	2,356	0	193	57.00
60.00	06000	LABORATORY	10,710	443	12,304	0	1,006	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	3,666	347	9,626	0	787	65.00
66.00	06600	PHYSICAL THERAPY	1,611	466	12,937	0	1,058	66.00
69.00	06900	ELECTROCARDIOLOGY	898	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,203	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,222	1,164	32,323	0	2,642	74.00
76.00	03550	OP PSYCH	629	262	7,276	0	595	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	12,563	728	20,207	0	1,652	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.01	04950	CANCER CENTER	0	0	0	0	0	93.01
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	147,659	28,607	549,468	16,054	43,511	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,628	5,860	162,735	0	13,303	192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER	658	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	163,945	34,467	712,203	16,054	56,814	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019Worksheet B
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	63,314					10.00
11.00	01100	CAFETERIA	0	42,354				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	49,039			12.00
13.00	01300	NURSING ADMINISTRATION	0	1,659	9,253	40,877		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	108	0	0	59,496	14.00
15.00	01500	PHARMACY	0	971	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,587	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	272	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	1,827	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	61,042	19,196	30,533	27,428	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,272	1,782	0	2,547	0	31.00
43.00	04300	NURSERY	0	540	9,253	772	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,285	0	1,837	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,538	0	2,197	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,322	0	0	0	54.00
55.01	03190	CHEMO THERAPY	0	99	0	0	0	55.01
56.00	05600	RADIOISOTOPE	0	179	0	0	0	56.00
57.00	05700	CT SCAN	0	466	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,325	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	336	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	287	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	59,496	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	OP PSYCH	0	271	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	4,266	0	6,096	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.01	04950	CANCER CENTER	0	0	0	0	0	93.01
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	63,314	39,316	49,039	40,877	59,496	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,733	0	0	0	192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER	0	305	0	0	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	63,314	42,354	49,039	40,877	59,496	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019Worksheet B
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	28,630					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	64,678				16.00
17.00	01700	SOCIAL SERVICE	0	0	20,553			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	482	60,190	19,127			30.00
31.00	03100	INTENSIVE CARE UNIT	97	4,371	1,389			31.00
43.00	04300	NURSERY	0	117	37			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	44	0	0			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0			52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0			54.00
55.01	03190	CHEMO THERAPY	0	0	0			55.01
56.00	05600	RADIOISOTOPE	0	0	0			56.00
57.00	05700	CT SCAN	0	0	0			57.00
60.00	06000	LABORATORY	0	0	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
65.00	06500	RESPIRATORY THERAPY	1	0	0			65.00
66.00	06600	PHYSICAL THERAPY	0	0	0			66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,970	0	0			73.00
74.00	07400	RENAL DIALYSIS	0	0	0			74.00
76.00	03550	OP PSYCH	0	0	0			76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	36	0	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.01	04950	CANCER CENTER	0	0	0			93.01
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,630	64,678	20,553	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0			192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER	0	0	0			194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	28,630	64,678	20,553	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0177

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	6,176					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		9,262				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				1,248,591	0	30.00
31.00	03100	INTENSIVE CARE UNIT				67,446	0	31.00
43.00	04300	NURSERY				28,487	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				186,128	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM				27,718	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				136,439	0	54.00
55.01	03190	CHEMO THERAPY				284	0	55.01
56.00	05600	RADIOISOTOPE				23,053	0	56.00
57.00	05700	CT SCAN				11,177	0	57.00
60.00	06000	LABORATORY				59,352	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
65.00	06500	RESPIRATORY THERAPY				43,349	0	65.00
66.00	06600	PHYSICAL THERAPY				53,198	0	66.00
69.00	06900	ELECTROCARDIOLOGY				1,269	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				59,496	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				32,173	0	73.00
74.00	07400	RENAL DIALYSIS				129,007	0	74.00
76.00	03550	OP PSYCH				29,719	0	76.00
76.97	07697	CARDIAC REHABILITATION				0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				0	0	76.98
76.99	07699	LITHOTRIPSY				0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY				103,642	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.01	04950	CANCER CENTER				0	0	93.01
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	2,240,528	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES				662,851	0	192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER				994	0	194.00
200.00		Cross Foot Adjustments	6,176	9,262	0	15,438	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,176	9,262	0	2,919,811	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0177

Period:
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To 03/31/2019Worksheet B
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Cost Center Description			Total	
			26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000	NURSING SCHOOL		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	1,248,591	30.00
31.00	03100	INTENSIVE CARE UNIT	67,446	31.00
43.00	04300	NURSERY	28,487	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	186,128	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,718	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	136,439	54.00
55.01	03190	CHEMO THERAPY	284	55.01
56.00	05600	RADIOISOTOPE	23,053	56.00
57.00	05700	CT SCAN	11,177	57.00
60.00	06000	LABORATORY	59,352	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
65.00	06500	RESPIRATORY THERAPY	43,349	65.00
66.00	06600	PHYSICAL THERAPY	53,198	66.00
69.00	06900	ELECTROCARDIOLOGY	1,269	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	59,496	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,173	73.00
74.00	07400	RENAL DIALYSIS	129,007	74.00
76.00	03550	OP PSYCH	29,719	76.00
76.97	07697	CARDIAC REHABILITATION	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699	LITHOTRIPSY	0	76.99
OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	103,642	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
93.01	04950	CANCER CENTER	0	93.01
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,240,528	118.00
NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	662,851	192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER	994	194.00
200.00		Cross Foot Adjustments	15,438	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,919,811	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	307,222					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,370	0	37,857,980			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,973	0	7,660,607	-15,793,816	54,448,135	5.00
6.00	00600	MAINTENANCE & REPAIRS	3,282	0	566,920	0	1,022,882	6.00
7.00	00700	OPERATION OF PLANT	73,103	0	593,560	0	2,793,980	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,200	0	0	0	160,020	8.00
9.00	00900	HOUSEKEEPING	3,935	0	1,018,071	0	1,794,014	9.00
10.00	01000	DIETARY	4,463	0	528,782	0	1,327,050	10.00
11.00	01100	CAFETERIA	3,120	0	344,639	0	296,812	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	3,660	0	0	0	180,462	12.00
13.00	01300	NURSING ADMINISTRATION	1,921	0	1,086,612	0	1,374,263	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,454	0	31,511	0	120,013	14.00
15.00	01500	PHARMACY	1,828	0	824,815	0	1,047,110	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,517	0	640,122	0	1,002,910	16.00
17.00	01700	SOCIAL SERVICE	1,493	0	115,244	0	152,591	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	1,027,096	0	1,327,132	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	697	0	0	0	8,944	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	73,066	0	10,670,711	0	14,561,243	30.00
31.00	03100	INTENSIVE CARE UNIT	3,190	0	1,233,355	0	3,723,397	31.00
43.00	04300	NURSERY	1,164	0	571,415	0	703,618	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	13,375	0	894,334	0	1,803,962	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,396	0	1,330,993	0	1,670,202	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,844	0	923,710	0	1,449,063	54.00
55.01	03190	CHEMO THERAPY	0	0	42,254	0	56,425	55.01
56.00	05600	RADIOISOTOPE	1,667	0	161,323	0	242,636	56.00
57.00	05700	CT SCAN	703	0	296,303	0	429,824	57.00
60.00	06000	LABORATORY	3,671	0	0	0	3,557,030	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,872	0	876,832	0	1,217,370	65.00
66.00	06600	PHYSICAL THERAPY	3,860	0	304,295	0	535,085	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	245,598	0	298,199	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,395,995	73.00
74.00	07400	RENAL DIALYSIS	9,644	0	0	0	405,895	74.00
76.00	03550	OP PSYCH	2,171	0	155,455	0	208,858	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	6,029	0	2,311,554	0	4,172,292	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.01	04950	CANCER CENTER	0	0	0	0	0	93.01
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	258,668	0	34,456,111	-15,793,816	49,039,277	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	48,554	0	3,311,948	0	5,190,182	192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER	0	0	89,921	0	218,676	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,919,811	0	7,608,705		15,793,816	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.503912	0.000000	0.200980		0.290071	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			13,020		163,945	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000344		0.003011	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: 14-0177

Period:
From 04/01/2018
To 03/31/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	285,597					6.00
7.00	00700	OPERATION OF PLANT	73,103	212,494				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,200	1,200	26,485			8.00
9.00	00900	HOUSEKEEPING	3,935	3,935	0	207,359		9.00
10.00	01000	DIETARY	4,463	4,463	0	4,463	52,677	10.00
11.00	01100	CAFETERIA	3,120	3,120	0	3,120	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	3,660	3,660	0	3,660	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,921	1,921	0	1,921	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,454	4,454	0	4,454	0	14.00
15.00	01500	PHARMACY	1,828	1,828	0	1,828	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,517	4,517	0	4,517	0	16.00
17.00	01700	SOCIAL SERVICE	1,493	1,493	0	1,493	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	697	697	0	697	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	73,066	73,066	24,647	73,066	50,787	30.00
31.00	03100	INTENSIVE CARE UNIT	3,190	3,190	1,790	3,190	1,890	31.00
43.00	04300	NURSERY	1,164	1,164	48	1,164	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	13,375	13,375	0	13,375	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,396	1,396	0	1,396	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,844	9,844	0	9,844	0	54.00
55.01	03190	CHEMO THERAPY	0	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	1,667	1,667	0	1,667	0	56.00
57.00	05700	CT SCAN	703	703	0	703	0	57.00
60.00	06000	LABORATORY	3,671	3,671	0	3,671	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,872	2,872	0	2,872	0	65.00
66.00	06600	PHYSICAL THERAPY	3,860	3,860	0	3,860	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	9,644	9,644	0	9,644	0	74.00
76.00	03550	OP PSYCH	2,171	2,171	0	2,171	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	6,029	6,029	0	6,029	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.01	04950	CANCER CENTER	0	0	0	0	0	93.01
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	237,043	163,940	26,485	158,805	52,677	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	48,554	48,554	0	48,554	0	192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,319,590	3,942,201	234,244	2,405,589	1,867,184	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.620462	18.552058	8.844402	11.601083	35.445906	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	34,467	712,203	16,054	56,814	63,314	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.120684	3.351638	0.606154	0.273989	1.201929	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: 14-0177

Period:
From 04/01/2018
To 03/31/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAFETERIA (FTES SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (FTES SERVED)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	44,156					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	53				12.00
13.00	01300	NURSING ADMINISTRATION	1,730	10	29,824			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	113	0	0	100		14.00
15.00	01500	PHARMACY	1,012	0	0	0	1,428,968	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,654	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	284	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,905	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	20,012	33	20,012	0	24,045	30.00
31.00	03100	INTENSIVE CARE UNIT	1,858	0	1,858	0	4,855	31.00
43.00	04300	NURSERY	563	10	563	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,340	0	1,340	0	2,192	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,603	0	1,603	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,378	0	0	0	12	54.00
55.01	03190	CHEMO THERAPY	103	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	187	0	0	0	0	56.00
57.00	05700	CT SCAN	486	0	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,381	0	0	0	65	65.00
66.00	06600	PHYSICAL THERAPY	350	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	299	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	100	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	1,395,995	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	OP PSYCH	283	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	4,448	0	4,448	0	1,804	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.01	04950	CANCER CENTER	0	0	0	0	0	93.01
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	40,989	53	29,824	100	1,428,968	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,849	0	0	0	0	192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER	318	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	491,402	360,081	1,926,891	310,965	1,425,674	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.128771	6,793.981132	64.608738	3,109.650000	0.997695	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	42,354	49,039	40,877	59,496	28,630	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.959190	925.264151	1.370608	594.960000	0.020035	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: 14-0177

Period:
From 04/01/2018
To 03/31/2019

Worksheet B-1

Date/Time Prepared:
8/24/2019 9:31 am

Cost Center Description			MEDICAL RECORDS & LIBRARY (PATIENT DAYS)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	26,485					16.00
17.00	01700	SOCIAL SERVICE	0	26,485				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			674,134	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	24,647	24,647	0	0	523,280	30.00
31.00	03100	INTENSIVE CARE UNIT	1,790	1,790	0	0	22,098	31.00
43.00	04300	NURSERY	48	48	0	0	22,687	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	44,785	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	7,071	54.00
55.01	03190	CHEMO THERAPY	0	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	31,526	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	OP PSYCH	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	0	22,687	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.01	04950	CANCER CENTER	0	0	0	0	0	93.01
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,485	26,485	0	0	674,134	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,469,305	251,930	0	0	1,733,295	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	55.476874	9.512177	0.000000	0.000000	2.571143	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	64,678	20,553	0	0	6,176	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.442062	0.776024	0.000000	0.000000	0.009161	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019

Worksheet B-1

Date/Time Prepared:
8/24/2019 9:31 am

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER		
			PRGM COSTS		
			APPRV (ASSIGNED TIME)		
			22.00	23.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	28,083		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	21,798	0	30.00
31.00	03100	INTENSIVE CARE UNIT	921	0	31.00
43.00	04300	NURSERY	945	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,866	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	295	0	54.00
55.01	03190	CHEMO THERAPY	0	0	55.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
60.00	06000	LABORATORY	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,313	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03550	OP PSYCH	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	945	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.01	04950	CANCER CENTER	0	0	93.01
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,083	0	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER	0	0	194.00
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	35,775	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.273902	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	9,262	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.329808	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019Worksheet C
Part I
Date/Time Prepared:
8/24/2019 9:31 am

				Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	26,709,608		26,709,608	0	26,709,608	30.00	
31.00	03100	INTENSIVE CARE UNIT	5,259,092		5,259,092	0	5,259,092	31.00	
43.00	04300	NURSERY	1,062,319		1,062,319	0	1,062,319	43.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	2,896,012		2,896,012	0	2,896,012	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,324,630		2,324,630	0	2,324,630	52.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,227,052		2,227,052	0	2,227,052	54.00	
55.01	03190	CHEMO THERAPY	73,938		73,938	0	73,938	55.01	
56.00	05600	RADIOISOTOPE	373,066		373,066	0	373,066	56.00	
57.00	05700	CT SCAN	584,358		584,358	0	584,358	57.00	
60.00	06000	LABORATORY	4,716,476		4,716,476	0	4,716,476	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	1,685,798	0	1,685,798	0	1,685,798	65.00	
66.00	06600	PHYSICAL THERAPY	828,419	0	828,419	0	828,419	66.00	
69.00	06900	ELECTROCARDIOLOGY	388,026		388,026	0	388,026	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	310,965		310,965	0	310,965	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	3,193,709		3,193,709	0	3,193,709	73.00	
74.00	07400	RENAL DIALYSIS	858,990		858,990	0	858,990	74.00	
76.00	03550	OP PSYCH	348,085		348,085	0	348,085	76.00	
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	5,930,884		5,930,884	0	5,930,884	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,045,267		2,045,267	0	2,045,267	92.00	
93.01	04950	CANCER CENTER	0		0	0	0	93.01	
200.00		Subtotal (see instructions)	61,816,694	0	61,816,694	0	61,816,694	200.00	
201.00		Less Observation Beds	2,045,267		2,045,267	0	2,045,267	201.00	
202.00		Total (see instructions)	59,771,427	0	59,771,427	0	59,771,427	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019Worksheet C
Part I
Date/Time Prepared:
8/24/2019 9:31 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	41,894,281		41,894,281			30.00
31.00	03100	INTENSIVE CARE UNIT	16,335,769		16,335,769			31.00
43.00	04300	NURSERY	285,051		285,051			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,960,899	4,543,750	9,504,649	0.304694	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	131,571	218,139	349,710	6.647308	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,643,593	6,335,882	9,979,475	0.223163	0.000000	54.00
55.01	03190	CHEMO THERAPY	148,329	282,960	431,289	0.171435	0.000000	55.01
56.00	05600	RADIOISOTOPE	697,427	583,033	1,280,460	0.291353	0.000000	56.00
57.00	05700	CT SCAN	4,784,775	13,873,397	18,658,172	0.031319	0.000000	57.00
60.00	06000	LABORATORY	21,503,298	28,702,268	50,205,566	0.093943	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	9,846,812	1,334,744	11,181,556	0.150766	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	569,578	942,011	1,511,589	0.548045	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	2,380,865	1,616,074	3,996,939	0.097081	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	107,409	120,183	227,592	1.366327	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,778,510	3,831,578	17,610,088	0.181357	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,728,236	433,194	4,161,430	0.206417	0.000000	74.00
76.00	03550	OP PSYCH	0	1,387,431	1,387,431	0.250885	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	4,811,944	8,802,442	13,614,386	0.435634	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	8,216,381	8,216,381	0.248926	0.000000	92.00
93.01	04950	CANCER CENTER	0	0	0	0.000000	0.000000	93.01
200.00		Subtotal (see instructions)	129,608,347	81,223,467	210,831,814			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	129,608,347	81,223,467	210,831,814			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-0177	Period: From 04/01/2018 To 03/31/2019	Worksheet C Part I Date/Time Prepared: 8/24/2019 9:31 am
				Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio			
			11.00			
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.304694			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6.647308			52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.223163			54.00
55.01	03190	CHEMO THERAPY	0.171435			55.01
56.00	05600	RADIOISOTOPE	0.291353			56.00
57.00	05700	CT SCAN	0.031319			57.00
60.00	06000	LABORATORY	0.093943			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.150766			65.00
66.00	06600	PHYSICAL THERAPY	0.548045			66.00
69.00	06900	ELECTROCARDIOLOGY	0.097081			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.366327			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.181357			73.00
74.00	07400	RENAL DIALYSIS	0.206417			74.00
76.00	03550	OP PSYCH	0.250885			76.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
	OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.435634			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.248926			92.00
93.01	04950	CANCER CENTER	0.000000			93.01
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: 14-0177

Period:
From 04/01/2018
To 03/31/2019Worksheet C
Part I
Date/Time Prepared:
8/24/2019 9:31 am

			Title XIX		Hospital	Cost		
	Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance		Total Costs
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	26,709,608		26,709,608	0	26,709,608	30.00
31.00	03100	INTENSIVE CARE UNIT	5,259,092		5,259,092	0	5,259,092	31.00
43.00	04300	NURSERY	1,062,319		1,062,319	0	1,062,319	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,896,012		2,896,012	0	2,896,012	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,324,630		2,324,630	0	2,324,630	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,227,052		2,227,052	0	2,227,052	54.00
55.01	03190	CHEMO THERAPY	73,938		73,938	0	73,938	55.01
56.00	05600	RADIOISOTOPE	373,066		373,066	0	373,066	56.00
57.00	05700	CT SCAN	584,358		584,358	0	584,358	57.00
60.00	06000	LABORATORY	4,716,476		4,716,476	0	4,716,476	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,685,798	0	1,685,798	0	1,685,798	65.00
66.00	06600	PHYSICAL THERAPY	828,419	0	828,419	0	828,419	66.00
69.00	06900	ELECTROCARDIOLOGY	388,026		388,026	0	388,026	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	310,965		310,965	0	310,965	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,193,709		3,193,709	0	3,193,709	73.00
74.00	07400	RENAL DIALYSIS	858,990		858,990	0	858,990	74.00
76.00	03550	OP PSYCH	348,085		348,085	0	348,085	76.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	5,930,884		5,930,884	0	5,930,884	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,045,267		2,045,267	0	2,045,267	92.00
93.01	04950	CANCER CENTER	0		0	0	0	93.01
200.00		Subtotal (see instructions)	61,816,694	0	61,816,694	0	61,816,694	200.00
201.00		Less Observation Beds	2,045,267		2,045,267	0	2,045,267	201.00
202.00		Total (see instructions)	59,771,427	0	59,771,427	0	59,771,427	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019Worksheet C
Part I
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			Title XIX			Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	41,894,281		41,894,281			30.00	
31.00	03100	INTENSIVE CARE UNIT	16,335,769		16,335,769			31.00	
43.00	04300	NURSERY	285,051		285,051			43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,960,899	4,543,750	9,504,649	0.304694	0.000000	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	131,571	218,139	349,710	6.647308	0.000000	52.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,643,593	6,335,882	9,979,475	0.223163	0.000000	54.00	
55.01	03190	CHEMO THERAPY	148,329	282,960	431,289	0.171435	0.000000	55.01	
56.00	05600	RADIOISOTOPE	697,427	583,033	1,280,460	0.291353	0.000000	56.00	
57.00	05700	CT SCAN	4,784,775	13,873,397	18,658,172	0.031319	0.000000	57.00	
60.00	06000	LABORATORY	21,503,298	28,702,268	50,205,566	0.093943	0.000000	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30	
65.00	06500	RESPIRATORY THERAPY	9,846,812	1,334,744	11,181,556	0.150766	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	569,578	942,011	1,511,589	0.548045	0.000000	66.00	
69.00	06900	ELECTROCARDIOLOGY	2,380,865	1,616,074	3,996,939	0.097081	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	107,409	120,183	227,592	1.366327	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	13,778,510	3,831,578	17,610,088	0.181357	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	3,728,236	433,194	4,161,430	0.206417	0.000000	74.00	
76.00	03550	OP PSYCH	0	1,387,431	1,387,431	0.250885	0.000000	76.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98	
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99	
	OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	4,811,944	8,802,442	13,614,386	0.435634	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	8,216,381	8,216,381	0.248926	0.000000	92.00	
93.01	04950	CANCER CENTER	0	0	0	0.000000	0.000000	93.01	
200.00		Subtotal (see instructions)	129,608,347	81,223,467	210,831,814			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	129,608,347	81,223,467	210,831,814			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019Worksheet C
Part I
Date/Time Prepared:
8/24/2019 9:31 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.01	03190	CHEMO THERAPY	0.000000			55.01
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
60.00	06000	LABORATORY	0.000000			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
76.00	03550	OP PSYCH	0.000000			76.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
93.01	04950	CANCER CENTER	0.000000			93.01
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019Worksheet D
Part I
Date/Time Prepared:
8/24/2019 9:31 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	1,248,591	0	1,248,591	26,667	46.82	30.00
31.00	INTENSIVE CARE UNIT	67,446		67,446	1,790	37.68	31.00
43.00	NURSERY	28,487		28,487	48	593.48	43.00
200.00	Total (lines 30 through 199)	1,344,524		1,344,524	28,505		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	6,221	291,267				30.00
31.00	INTENSIVE CARE UNIT	493	18,576				31.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	6,714	309,843				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019Worksheet D
Part II
Date/Time Prepared:
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Cost Center Description			Title XVIII		Hospital	PPS	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	186,128	9,504,649	0.019583	1,328,460	26,015
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,718	349,710	0.079260	9,040	717
54.00	05400	RADIOLOGY-DIAGNOSTIC	136,439	9,979,475	0.013672	1,471,628	20,120
55.01	03190	CHEMO THERAPY	284	431,289	0.000658	60,605	40
56.00	05600	RADIOISOTOPE	23,053	1,280,460	0.018004	268,188	4,828
57.00	05700	CT SCAN	11,177	18,658,172	0.000599	2,406,881	1,442
60.00	06000	LABORATORY	59,352	50,205,566	0.001182	8,521,693	10,073
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0
65.00	06500	RESPIRATORY THERAPY	43,349	11,181,556	0.003877	2,990,748	11,595
66.00	06600	PHYSICAL THERAPY	53,198	1,511,589	0.035193	226,482	7,971
69.00	06900	ELECTROCARDIOLOGY	1,269	3,996,939	0.000317	876,426	278
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	59,496	227,592	0.261415	27,457	7,178
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	32,173	17,610,088	0.001827	4,078,231	7,451
74.00	07400	RENAL DIALYSIS	129,007	4,161,430	0.031001	1,829,555	56,718
76.00	03550	OP PSYCH	29,719	1,387,431	0.021420	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	103,642	13,614,386	0.007613	1,027,986	7,826
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	95,610	8,216,381	0.011637	0	0
93.01	04950	CANCER CENTER	0	0	0.000000	0	0
200.00		Total (lines 50 through 199)	991,614	152,316,713		25,123,380	162,252

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0177		Period: From 04/01/2018 To 03/31/2019		Worksheet D Part III Date/Time Prepared: 8/24/2019 9:31 am	
					Title XVIII		Hospital		PPS	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00
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	26,667	0.00	6,221		30.00
31.00	03100	INTENSIVE CARE UNIT			0	1,790	0.00	493		31.00
43.00	04300	NURSERY			0	48	0.00	0		43.00
200.00		Total (lines 30 through 199)			0	28,505		6,714		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: 14-0177

Period:
From 04/01/2018
To 03/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/24/2019 9:31 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	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.01	03190	CHEMO THERAPY	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03550	OP PSYCH	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
93.01	04950	CANCER CENTER	0	0	0	0	93.01
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019

Worksheet D
Part IV
Date/Time Prepared:
8/24/2019 9:31 am

				Title XVIII		Hospital	PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	9,504,649	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	349,710	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	9,979,475	0.000000	54.00
55.01	03190	CHEMO THERAPY	0	0	0	431,289	0.000000	55.01
56.00	05600	RADIOISOTOPE	0	0	0	1,280,460	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	18,658,172	0.000000	57.00
60.00	06000	LABORATORY	0	0	0	50,205,566	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,181,556	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,511,589	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,996,939	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	227,592	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	17,610,088	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,161,430	0.000000	74.00
76.00	03550	OP PSYCH	0	0	0	1,387,431	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	13,614,386	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	8,216,381	0.000000	92.00
93.01	04950	CANCER CENTER	0	0	0	0	0.000000	93.01
200.00		Total (lines 50 through 199)	0	0	0	152,316,713		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019

Worksheet D
Part IV
Date/Time Prepared:
8/24/2019 9:31 am

Cost Center Description			Title XVIII		Hospital		PPS	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	1,328,460	0	578,978	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	9,040	0	2,412	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,471,628	0	573,998	0	54.00
55.01	03190	CHEMO THERAPY	0.000000	60,605	0	137,081	0	55.01
56.00	05600	RADIOISOTOPE	0.000000	268,188	0	138,611	0	56.00
57.00	05700	CT SCAN	0.000000	2,406,881	0	1,295,173	0	57.00
60.00	06000	LABORATORY	0.000000	8,521,693	0	1,470,547	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	2,990,748	0	99,372	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	226,482	0	3,113	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	876,426	0	308,465	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	27,457	0	27,446	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	4,078,231	0	621,848	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	1,829,555	0	92,169	0	74.00
76.00	03550	OP PSYCH	0.000000	0	0	6,864	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.000000	1,027,986	0	751,714	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	862,462	0	92.00
93.01	04950	CANCER CENTER	0.000000	0	0	0	0	93.01
200.00		Total (lines 50 through 199)		25,123,380	0	6,970,253	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019Worksheet D
Part V
Date/Time Prepared:
8/24/2019 9:31 am

			Title XVIII		Hospital		PPS	
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		PPS Services (see inst.)	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.304694	578,978	0	0	176,411	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6.647308	2,412	0	0	16,033	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.223163	573,998	0	0	128,095	54.00
55.01	03190	CHEMO THERAPY	0.171435	137,081	0	0	23,500	55.01
56.00	05600	RADIOISOTOPE	0.291353	138,611	0	0	40,385	56.00
57.00	05700	CT SCAN	0.031319	1,295,173	0	0	40,564	57.00
60.00	06000	LABORATORY	0.093943	1,470,547	0	0	138,148	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.150766	99,372	0	0	14,982	65.00
66.00	06600	PHYSICAL THERAPY	0.548045	3,113	0	0	1,706	66.00
69.00	06900	ELECTROCARDIOLOGY	0.097081	308,465	0	0	29,946	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.366327	27,446	0	0	37,500	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	0.181357	621,848	0	511	112,776	73.00
74.00	07400	RENAL DIALYSIS	0.206417	92,169	0	0	19,025	74.00
76.00	03550	OP PSYCH	0.250885	6,864	0	0	1,722	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.435634	751,714	0	0	327,472	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.248926	862,462	0	0	214,689	92.00
93.01	04950	CANCER CENTER	0.000000	0	0	0	0	93.01
200.00		Subtotal (see instructions)		6,970,253	0	511	1,322,954	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		6,970,253	0	511	1,322,954	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019Worksheet D
Part V
Date/Time Prepared:
8/24/2019 9:31 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.01	03190	CHEMO THERAPY	0	0		55.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	93		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03550	OP PSYCH	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
	OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.01	04950	CANCER CENTER	0	0		93.01
200.00		Subtotal (see instructions)	0	93		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	93		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0177	Period: From 04/01/2018 To 03/31/2019	Worksheet D-1 Date/Time Prepared: 8/24/2019 9:31 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)			26,667	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			26,667	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)			24,625	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			6,221	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)			26,709,608	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0	25.00
26.00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			26,709,608	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)			26,709,608	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)			1,001.60	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			6,230,954	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)			6,230,954	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019

Worksheet D-1

Date/Time Prepared:
8/24/2019 9:31 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	5,259,092	1,790	2,938.04	493	1,448,454		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)					4,020,457		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					11,699,865		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)					309,843		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					162,252		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					472,095		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					11,227,770		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)					2,042		87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,001.60		88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,045,267		89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019

Worksheet D-1

Date/Time Prepared:
8/24/2019 9:31 am

Cost Center Description		Title XVIII		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,248,591	26,709,608	0.046747	2,045,267	95,610
91.00	Nursing School cost	0	26,709,608	0.000000	2,045,267	0
92.00	Allied health cost	0	26,709,608	0.000000	2,045,267	0
93.00	All other Medical Education	0	26,709,608	0.000000	2,045,267	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0177	Period: From 04/01/2018 To 03/31/2019	Worksheet D-1 Date/Time Prepared: 8/24/2019 9:31 am
Cost Center Description		Title XIX	Hospital	Cost
PART I - ALL PROVIDER COMPONENTS				1.00
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			26,667 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			26,667 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)			24,625 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			2,721 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)			48 15.00
16.00	Nursery days (title V or XIX only)			48 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			26,709,608 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			26,709,608 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)			26,709,608 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)			1,001.60 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			2,725,354 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			2,725,354 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019

Worksheet D-1

Date/Time Prepared:
8/24/2019 9:31 am

		Title XIX		Hospital		Cost	
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)	1,062,319	48	22,131.65	48	1,062,319	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	5,259,092	1,790	2,938.04	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					798,918	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,586,591	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					2,042	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,001.60	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,045,267	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019

Worksheet D-1

Date/Time Prepared:
8/24/2019 9:31 am

Cost Center Description		Title XIX		Hospital		Cost	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,248,591	26,709,608	0.046747	2,045,267	95,610	90.00
91.00	Nursing School cost	0	26,709,608	0.000000	2,045,267	0	91.00
92.00	Allied health cost	0	26,709,608	0.000000	2,045,267	0	92.00
93.00	All other Medical Education	0	26,709,608	0.000000	2,045,267	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0177	Period: From 04/01/2018 To 03/31/2019	Worksheet D-3 Date/Time Prepared: 8/24/2019 9:31 am	
			Title XVIII	Hospital	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		11,813,674		30.00
31.00	03100	INTENSIVE CARE UNIT		4,207,633		31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.304694	1,328,460	404,774	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6.647308	9,040	60,092	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.223163	1,471,628	328,413	54.00
55.01	03190	CHEMO THERAPY	0.171435	60,605	10,390	55.01
56.00	05600	RADIOISOTOPE	0.291353	268,188	78,137	56.00
57.00	05700	CT SCAN	0.031319	2,406,881	75,381	57.00
60.00	06000	LABORATORY	0.093943	8,521,693	800,553	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.150766	2,990,748	450,903	65.00
66.00	06600	PHYSICAL THERAPY	0.548045	226,482	124,122	66.00
69.00	06900	ELECTROCARDIOLOGY	0.097081	876,426	85,084	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.366327	27,457	37,515	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.181357	4,078,231	739,616	73.00
74.00	07400	RENAL DIALYSIS	0.206417	1,829,555	377,651	74.00
76.00	03550	OP PSYCH	0.250885	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.435634	1,027,986	447,826	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.248926	0	0	92.00
93.01	04950	CANCER CENTER	0.000000	0	0	93.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		25,123,380	4,020,457	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00		Net charges (line 200 minus line 201)		25,123,380		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0177	Period: From 04/01/2018 To 03/31/2019	Worksheet D-3 Date/Time Prepared: 8/24/2019 9:31 am
Cost Center Description			Title XIX	Hospital	Cost
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		3,570,776	30.00
31.00	03100	INTENSIVE CARE UNIT		772,998	31.00
43.00	04300	NURSERY		52,858	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.304694	317,334	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6.647308	9,553	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.223163	250,008	54.00
55.01	03190	CHEMO THERAPY	0.171435	0	55.01
56.00	05600	RADIOISOTOPE	0.291353	31,055	56.00
57.00	05700	CT SCAN	0.031319	287,095	57.00
60.00	06000	LABORATORY	0.093943	1,474,810	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.150766	288,015	65.00
66.00	06600	PHYSICAL THERAPY	0.548045	27,695	66.00
69.00	06900	ELECTROCARDIOLOGY	0.097081	130,604	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.366327	2,882	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.181357	845,632	73.00
74.00	07400	RENAL DIALYSIS	0.206417	63,365	74.00
76.00	03550	OP PSYCH	0.250885	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.435634	423,947	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.248926	0	92.00
93.01	04950	CANCER CENTER	0.000000	0	93.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,151,995	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)		4,151,995	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019Worksheet E
Part A
Date/Time Prepared:
8/24/2019 9:31 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)			4,320,624	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			4,320,624	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)			113,420	2.00
2.01	Outlier reconciliation amount			0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)			0	2.02
3.00	Managed Care Simulated Payments			880,455	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			195.14	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)			11.29	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)			11.29	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			17.92	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)			11.29	12.00
13.00	Total allowable FTE count for the prior year.			11.29	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.			11.16	14.00
15.00	Sum of lines 12 through 14 divided by 3.			11.25	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			11.25	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.057651	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.057880	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.057651	21.00
22.00	IME payment adjustment (see instructions)			267,844	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			27,291	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)			6.63	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)			267,844	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			27,291	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			19.64	30.00
31.00	Percentage of Medicaid patient days (see instructions)			55.92	31.00
32.00	Sum of lines 30 and 31			75.56	32.00
33.00	Allowable disproportionate share percentage (see instructions)			51.55	33.00
34.00	Disproportionate share adjustment (see instructions)			1,113,642	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0177	Period: From 04/01/2018 To 03/31/2019	Worksheet E Part A Date/Time Prepared: 8/24/2019 9:31 am
		Title XVIII	Hospital	PPS
			Prior to 10/1	On/After 10/1
			1.00	2.00
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)		0	0 35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	3,142,923	2,834,065	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,575,767	1,413,150	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,988,917		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
			Before 1/1	On/After 1/1
			1.00	1.01
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0 41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0 41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	13,125,071		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		13,152,362	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		855,356	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).		339,630	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)		14,347,348	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		14,347,348	61.00
62.00	Deductibles billed to program beneficiaries		941,936	62.00
63.00	Coinsurance billed to program beneficiaries		237,859	63.00
64.00	Allowable bad debts (see instructions)		734,062	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		477,140	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		477,275	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		13,644,693	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 (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		7,829	70.93
70.94	HRR adjustment amount (see instructions)		-38,409	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0177	Period: From 04/01/2018 To 03/31/2019	Worksheet E Part A Date/Time Prepared: 8/24/2019 9:31 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)		0	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		13,614,113	71.00	
71.01	Sequestration adjustment (see instructions)		272,282	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
72.00	Interim payments		12,840,042	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)		501,789	74.00	
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		433,749	75.00	
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00	
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00	
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00	
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00	
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00	
95.00	Time value of money for operating expenses (see instructions)		0	95.00	
96.00	Time value of money for capital related expenses (see instructions)		0	96.00	
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	100.00	
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00	
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00	
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00	
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00	
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00	
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00	
202.00	Medicare discharges (see instructions)			202.00	
203.00	Case-mix adjustment factor (see instructions)			203.00	
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount			204.00	
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00	
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00	
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00	
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00	
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00	
210.00	Reserved for future use			210.00	
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00	
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00	
213.00	Low-volume adjustment (see instructions)			213.00	
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0177	Period: From 04/01/2018 To 03/31/2019	Worksheet E Part B Date/Time Prepared: 8/24/2019 9:31 am
		Title XVIII	Hospital	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		93	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		1,322,954	2.00
3.00	OPPS payments		822,204	3.00
4.00	Outlier payment (see instructions)		7,086	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		93	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		511	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)		511	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)		511	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		418	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)		93	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)		829,290	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)		177,851	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)		651,532	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		38,406	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)		689,938	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		689,938	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)		96,081	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		62,453	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		48,680	36.00
37.00	Subtotal (see instructions)		752,391	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		752,391	40.00
40.01	Sequestration adjustment (see instructions)		15,048	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		761,658	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-24,315	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019Worksheet E-1
Part I
Date/Time Prepared:
8/24/2019 9:31 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		12,840,042		761,658	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)		12,840,042		761,658	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		501,789		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		24,315	6.02
7.00	Total Medicare program liability (see instructions)		13,341,831		737,343	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: 14-0177	Period: From 04/01/2018 To 03/31/2019	Worksheet E-1 Part II Date/Time Prepared: 8/24/2019 9:31 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019Worksheet E-3
Part VII
Date/Time Prepared:
8/24/2019 9:31 am

		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		4,586,591		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		4,586,591	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		4,586,591	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		4,396,632		8.00
9.00	Ancillary service charges		4,151,995	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		8,548,627	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		8,548,627	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		3,962,036	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		4,586,591	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		4,586,591	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		4,586,591	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		4,586,591	0	36.00
37.00	PAYMENT RECONCILIATION		-2,435,875	0	37.00
38.00	Subtotal (line 36 ± line 37)		2,150,716	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		2,150,716	0	40.00
41.00	Interim payments		2,150,716	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0177	Period: From 04/01/2018 To 03/31/2019	Worksheet E-4 Date/Time Prepared: 8/24/2019 9:31 am	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			11.29	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			11.29	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			17.92	6.00
7.00	Enter the lesser of line 5 or line 6			11.29	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	17.92	0.00	17.92	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	11.29	0.00	11.29	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	11.29	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	11.29	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	11.16	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	11.25	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	11.25	0.00		17.00
18.00	Per resident amount	122,430.68	116,055.36		18.00
19.00	Approved amount for resident costs	1,377,345	0	1,377,345	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			6.63	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			1,377,345	25.00
		Inpatient Part	Managed care		
		A			
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	6,714	630		26.00
27.00	Total Inpatient Days (see instructions)	26,433	26,433		27.00
28.00	Ratio of inpatient days to total inpatient days	0.254001	0.023834		28.00
29.00	Program direct GME amount	349,847	32,828		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		4,639		30.00
31.00	Net Program direct GME amount			378,036	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0177	Period: From 04/01/2018 To 03/31/2019	Worksheet E-4 Date/Time Prepared: 8/24/2019 9:31 am
		Title XVIII	Hospital	PPS
			1.00	
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		4,161,430	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		11,699,865	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		11,699,865	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		1,323,047	42.00
43.00	Primary payer payments (see instructions)		0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		1,323,047	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		13,022,912	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.898406	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.101594	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		378,036	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		339,630	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		38,406	50.00

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

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019

Worksheet G

Date/Time Prepared:
8/24/2019 9:31 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	8,003,082	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	122,977,934	0	0	0	4.00
5.00	Other receivable	5,321,820	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-80,726,719	0	0	0	6.00
7.00	Inventory	1,152,092	0	0	0	7.00
8.00	Prepaid expenses	196,479	0	0	0	8.00
9.00	Other current assets	66,451,280	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)	123,375,968	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,482,024	0	0	0	12.00
13.00	Land improvements	180,870	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	57,921,276	0	0	0	15.00
16.00	Accumulated depreciation	-41,685,502	0	0	0	16.00
17.00	Leasehold improvements	2,260	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	171,770	0	0	0	21.00
22.00	Accumulated depreciation	-171,770	0	0	0	22.00
23.00	Major movable equipment	34,850,244	0	0	0	23.00
24.00	Accumulated depreciation	-28,853,377	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	24,897,795	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	486,163	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	913	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	487,076	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	148,760,839	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	8,715,831	0	0	0	37.00
38.00	Salaries, wages, and fees payable	6,030,127	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	9,804,197	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	24,550,155	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	10,812,966	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	10,812,966	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	35,363,121	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	113,397,718				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)	113,397,718	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	148,760,839	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019

Worksheet G-1

Date/Time Prepared:
8/24/2019 9:31 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		104,651,740		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		8,745,978				2.00
3.00	Total (sum of line 1 and line 2)		113,397,718		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		113,397,718		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		113,397,718		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
8/24/2019 9:31 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	42,003,548		42,003,548	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)	42,003,548		42,003,548	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	16,332,321		16,332,321	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)	16,332,321		16,332,321	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	58,335,869		58,335,869	17.00
18.00	Ancillary services	71,230,212	81,266,300	152,496,512	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	129,566,081	81,266,300	210,832,381	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		82,321,971		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	EXP RECONCILIATION	10,345			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)		10,345		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		82,311,626		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0177

Period:
From 04/01/2018
To 03/31/2019

Worksheet G-3

Date/Time Prepared:
8/24/2019 9:31 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	210,832,381	1.00
2.00	Less contractual allowances and discounts on patients' accounts	127,390,774	2.00
3.00	Net patient revenues (line 1 minus line 2)	83,441,607	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	82,311,626	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,129,981	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	4,633,034	6.00
7.00	Income from investments	209,065	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	258,834	14.00
15.00	Revenue from rental of living quarters	182,891	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	5,213	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	556,201	22.00
23.00	Governmental appropriations	0	23.00
24.00	MED SCHOOL BILLING	1,264,337	24.00
24.01	RADIOLOGY PHY REV	397,503	24.01
24.02	OTHER INCOME	108,919	24.02
24.03	OTHER (SPECIFY)	0	24.03
24.04	OTHER (SPECIFY)	0	24.04
24.05	OTHER (SPECIFY)	0	24.05
25.00	Total other income (sum of lines 6-24)	7,615,997	25.00
26.00	Total (line 5 plus line 25)	8,745,978	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	8,745,978	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0177	Period: From 04/01/2018 To 03/31/2019	Worksheet L Parts I-III Date/Time Prepared: 8/24/2019 9:31 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		703,392	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		4,181	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)		72.42	3.00
4.00	Number of interns & residents (see instructions)		11.25	4.00
5.00	Indirect medical education percentage (see instructions)		4.48	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)		31,512	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		19.64	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		55.92	8.00
9.00	Sum of lines 7 and 8		75.56	9.00
10.00	Allowable disproportionate share percentage (see instructions)		16.53	10.00
11.00	Disproportionate share adjustment (see instructions)		116,271	11.00
12.00	Total prospective capital payments (see instructions)		855,356	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