

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: 14-0184

Period:
From 05/01/2018
To 04/30/2019

Worksheet S
Parts I-III
Date/Time Prepared:
9/26/2019 12:56 pm

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 9/26/2019	Time: 12:56 pm
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status	6. Date Received:	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. ☐ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter
	(3) Settled with Audit	9. ☐ Final Report for this Provider CCN	number of times reopened = 0-9.
	(4) Reopened		
	(5) Amended		

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HEARTLAND REGIONAL MEDICAL CENTER (14-0184) for the cost reporting period beginning 05/01/2018 and ending 04/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) GAY HUFF

Officer or Administrator of Provider(s)

CFO

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	5,660	108,966	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	5,660	108,966	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: 14-0184		Period: From 05/01/2018 To 04/30/2019		Worksheet S-2 Part I Date/Time Prepared: 9/26/2019 12:56 pm	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 917 WEST MAIN ST			PO Box:				1.00		
2.00	City: MARION			State: IL		Zip Code: 62959		County: WILLIAMSON		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	XIX
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		HEARTLAND REGIONAL MEDICAL CENTER	140184	16060	1	07/01/1996	N	P	O
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		HEARTLAND REGIONAL MEDICAL CENTER	14U184	16060		03/23/1999	N	P	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
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)						05/01/2018	04/30/2019		20.00
21.00	Type of Control (see instructions)						4			21.00
							1.00	2.00		3.00
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		23.00	
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
				1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			666	621	0	7	2,473	0	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0184		Period: From 05/01/2018 To 04/30/2019		Worksheet S-2 Part I Date/Time Prepared: 9/26/2019 12:56 pm		
				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	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.						N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.						N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.						N	N	N	48.00
Teaching Hospitals										
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.						N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.									57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.									58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.						N			59.00
						NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
						1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)						N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019Worksheet S-2
Part I
Date/Time Prepared:
9/26/2019 12:56 pm

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0184	Period: From 05/01/2018 To 04/30/2019	Worksheet S-2 Part I Date/Time Prepared: 9/26/2019 12:56 pm	
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
			1.00	2.00	3.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	62,978	95,666	0	118.01
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		HB0776	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0184		Period: From 05/01/2018 To 04/30/2019		Worksheet S-2 Part I Date/Time Prepared: 9/26/2019 12:56 pm	
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: QUORUM HEALTH		Contractor's Name: WISCONSIN PHYSICIAN SERVICES		Contractor's Number: 10101		141.00		
142.00	Street: 1573 MALLORY LANE		PO Box:				142.00		
143.00	City: BRENTWOOD		State: TN		Zip Code: 37027		143.00		
								1.00	
144.00 Are provider based physicians' costs included in Worksheet A?								Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					Y		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					N		146.00	
								1.00	
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital			N	N	N	N		155.00
156.00	Subprovider - IPF			N	N	N	N		156.00
157.00	Subprovider - IRF			N	N	N	N		157.00
158.00	SUBPROVIDER								158.00
159.00	SNF			N	N	N	N		159.00
160.00	HOME HEALTH AGENCY			N	N	N	N		160.00
161.00	CMHC				N	N	N		161.00
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
				Name	County	State	Zip Code	CBSA	FTE/Campus
				0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							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)					05/01/2018	04/30/2019		170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N		0	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0184		Period: From 05/01/2018 To 04/30/2019		Worksheet S-2 Part II Date/Time Prepared: 9/26/2019 12:56 pm	
				Y/N	Date		
				1.00	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	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			Y			3.00
				Y/N	Type	Date	
				1.00	2.00	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.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	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)			Y	08/15/2019	Y	08/15/2019
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0184		Period: From 05/01/2018 To 04/30/2019		Worksheet S-2 Part II Date/Time Prepared: 9/26/2019 12:56 pm	
		Description		Y/N	Y/N		
		0		1.00	3.00		
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00	
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00	
					1.00		
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)							
Capital Related Cost							
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00	
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00	
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				Y	24.00	
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00	
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00	
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00	
Interest Expense							
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00	
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00	
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00	
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00	
Purchased Services							
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00	
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00	
Provider-Based Physicians							
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00	
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00	
				Y/N	Date		
				1.00	2.00		
Home Office Costs							
36.00	Were home office costs claimed on the cost report?				Y	36.00	
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				Y	37.00	
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				Y	12/31/2018	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				N	39.00	
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				N	40.00	
				1.00		2.00	
Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JOSEPH		MORAN		41.00	
42.00	Enter the employer/company name of the cost report preparer.	QUORUM HEALTH CORP				42.00	
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-221-3613		JOSEPH_MORAN@QUORUMHEALTH.COM		43.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019Worksheet S-2
Part II
Date/Time Prepared:
9/26/2019 12:56 pm

		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT 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: 14-0184

Period:
From 05/01/2018
To 04/30/2019Worksheet S-3
Part I
Date/Time Prepared:
9/26/2019 12:56 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	76	27,740	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)		76	27,740	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	18	6,570	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)		94	34,310	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)		94			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: 14-0184

Period:
From 05/01/2018
To 04/30/2019Worksheet S-3
Part I
Date/Time Prepared:
9/26/2019 12:56 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4,128	512	8,373			1.00
2.00	HMO and other (see instructions)	608	3,101				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)	4,128	512	8,373			7.00
8.00	INTENSIVE CARE UNIT	714	11	1,448			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		143	1,301			13.00
14.00	Total (see instructions)	4,842	666	11,122	0.00	352.25	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	352.25	27.00
28.00	Observation Bed Days		0	2,542			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	245			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: 14-0184

Period:
From 05/01/2018
To 04/30/2019Worksheet S-3
Part I
Date/Time Prepared:
9/26/2019 12:56 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,536	209	3,820	1.00
2.00 HMO and other (see instructions)			184	757		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	1,536	209	3,820	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: 14-0184

Period:
From 05/01/2018
To 04/30/2019Worksheet S-3
Part II
Date/Time Prepared:
9/26/2019 12:56 pm

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	23,669,619	0	23,669,619	732,677.00	32.31 1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00 2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00 3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00 4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00 4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00 5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00 6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00 7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00 7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00 8.00
9.00	SNF	44.00	0	0	0	0.00	0.00 9.00
10.00	Excluded area salaries (see instructions)		119,434	3,747	123,181	4,170.00	29.54 10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		476,374	0	476,374	12,481.00	38.17 11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00 12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00 13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00 14.00
14.01	Home office salaries		1,280,768	0	1,280,768	16,701.00	76.69 14.01
14.02	Related organization salaries		0	0	0	0.00	0.00 14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00 15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		5,511,994	0	5,511,994		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		13,610	0	13,610		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		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	264,995	0	264,995	8,214.00	32.26 26.00
27.00	Administrative & General	5.00	3,366,680	-82,840	3,283,840	103,324.00	31.78 27.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019Worksheet S-3
Part II
Date/Time Prepared:
9/26/2019 12:56 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	395,443	0	395,443	14,821.00	26.68	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,458,838	0	1,458,838	34,193.00	42.66	38.00
39.00	Central Services and Supply	14.00	236,826	0	236,826	13,071.00	18.12	39.00
40.00	Pharmacy	15.00	1,191,129	0	1,191,129	26,532.00	44.89	40.00
41.00	Medical Records & Medical Records Library	16.00	369,689	0	369,689	18,477.00	20.01	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019Worksheet S-3
Part III
Date/Time Prepared:
9/26/2019 12:56 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	23,669,619	0	23,669,619	732,677.00	32.31	1.00
2.00	Excluded area salaries (see instructions)	119,434	3,747	123,181	4,170.00	29.54	2.00
3.00	Subtotal salaries (line 1 minus line 2)	23,550,185	-3,747	23,546,438	728,507.00	32.32	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,757,142	0	1,757,142	29,182.00	60.21	4.00
5.00	Subtotal wage-related costs (see inst.)	5,511,994	0	5,511,994	0.00	23.41	5.00
6.00	Total (sum of lines 3 thru 5)	30,819,321	-3,747	30,815,574	757,689.00	40.67	6.00
7.00	Total overhead cost (see instructions)	7,283,600	-82,840	7,200,760	218,632.00	32.94	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019Worksheet S-3
Part IV
Date/Time Prepared:
9/26/2019 12:56 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	322,579	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	3,121,363	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	28,915	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	17,676	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	-1,742	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	7,488	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	155,742	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	1,363,700	17.00
18.00	Medicare Taxes - Employers Portion Only	318,930	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	153,230	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	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,487,881	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019Worksheet S-3
Part V
Date/Time Prepared:
9/26/2019 12:56 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	476,374	5,487,881	1.00
2.00	Hospital	476,374	5,487,881	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: 14-0184	Period: From 05/01/2018 To 04/30/2019	Worksheet S-10 Date/Time Prepared: 9/26/2019 12:56 pm	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.105336		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		7,469,326		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		6,571,529		5.00
6.00	Medicaid charges		133,368,955		6.00
7.00	Medicaid cost (line 1 times line 6)		14,048,552		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		7,697		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)		7,697		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)	4,207,382	0	4,207,382	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	443,189	0	443,189	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)	443,189	0	443,189	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)		6,261,257		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		591,408		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		909,859		27.01
28.00	Non-Medicare bad debt expense (see instructions)		5,351,398		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		882,146		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,325,335		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,333,032		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019

Worksheet A

Date/Time Prepared:
9/26/2019 12:56 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,335,112	1,335,112	686,199	2,021,311	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,814,866	2,814,866	1,013,807	3,828,673	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	264,995	122,446	387,441	3,708,635	4,096,076	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,366,680	19,515,294	22,881,974	-4,915,541	17,966,433	5.00
7.00	00700	OPERATION OF PLANT	395,443	2,400,962	2,796,405	-352	2,796,053	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	286,315	286,315	0	286,315	8.00
9.00	00900	HOUSEKEEPING	0	1,200,348	1,200,348	510	1,200,858	9.00
10.00	01000	DIETARY	0	1,545,474	1,545,474	-496,137	1,049,337	10.00
11.00	01100	CAFETERIA	0	0	0	496,137	496,137	11.00
13.00	01300	NURSING ADMINISTRATION	1,458,838	272,874	1,731,712	-18,936	1,712,776	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	236,826	6,869,018	7,105,844	-2,814,283	4,291,561	14.00
15.00	01500	PHARMACY	1,191,129	2,657,044	3,848,173	-2,341,180	1,506,993	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	369,689	765,751	1,135,440	0	1,135,440	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,162,467	2,585,526	5,747,993	-297,592	5,450,401	30.00
31.00	03100	INTENSIVE CARE UNIT	1,420,588	449,114	1,869,702	-17,339	1,852,363	31.00
43.00	04300	NURSERY	349,373	70,368	419,741	189,552	609,293	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,269,371	2,916,054	5,185,425	99,193	5,284,618	50.00
51.00	05100	RECOVERY ROOM	439,565	42,608	482,173	-482,173	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,150,714	144,618	1,295,332	54,408	1,349,740	52.00
53.00	05300	ANESTHESIOLOGY	0	3,943,865	3,943,865	-3,059	3,940,806	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,193,596	1,348,837	2,542,433	-263,635	2,278,798	54.00
54.01	05401	ULTRASOUND	171,950	17,056	189,006	0	189,006	54.01
56.00	05600	RADIOISOTOPE	196,846	309,972	506,818	0	506,818	56.00
57.00	05700	CT SCAN	352,552	74,935	427,487	0	427,487	57.00
58.00	05800	MRI	101,294	11,152	112,446	0	112,446	58.00
60.00	06000	LABORATORY	1,144,182	1,990,777	3,134,959	-467,383	2,667,576	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	444,939	444,939	62.00
65.00	06500	RESPIRATORY THERAPY	572,047	217,419	789,466	-89,702	699,764	65.00
66.00	06600	PHYSICAL THERAPY	599,256	98,796	698,052	-36,930	661,122	66.00
67.00	06700	OCCUPATIONAL THERAPY	131,504	10,620	142,124	81,491	223,615	67.00
68.00	06800	SPEECH PATHOLOGY	120,060	9,737	129,797	-57,336	72,461	68.00
69.00	06900	ELECTROCARDIOLOGY	1,161,805	1,605,063	2,766,868	-74,893	2,691,975	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	561,860	561,860	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,282,021	2,282,021	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,292,809	2,292,809	73.00
74.00	07400	RENAL DIALYSIS	0	341,320	341,320	0	341,320	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	238,283	238,283	0	238,283	76.01
76.03	03951	WOUND CARE	107,316	46,615	153,931	-8,866	145,065	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	1,622,099	2,979,975	4,602,074	284,487	4,886,561	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	79,093	205,394	284,487	-284,487	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,629,278	59,443,608	83,072,886	-473,776	82,599,110	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	10,549	10,549	0	10,549	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	40,341	7,371	47,712	0	47,712	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	0	473,776	473,776	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	23,669,619	59,461,528	83,131,147	0	83,131,147	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019

Worksheet A

Date/Time Prepared:
9/26/2019 12:56 pm

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	322,728	2,344,039	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-897,975	2,930,698	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-770	4,095,306	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-6,641,829	11,324,604	5.00
7.00	00700	OPERATION OF PLANT	-13,112	2,782,941	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	286,315	8.00
9.00	00900	HOUSEKEEPING	0	1,200,858	9.00
10.00	01000	DIETARY	0	1,049,337	10.00
11.00	01100	CAFETERIA	-224,171	271,966	11.00
13.00	01300	NURSING ADMINISTRATION	-830	1,711,946	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,291,561	14.00
15.00	01500	PHARMACY	0	1,506,993	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-241	1,135,199	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,653,622	3,796,779	30.00
31.00	03100	INTENSIVE CARE UNIT	-128,009	1,724,354	31.00
43.00	04300	NURSERY	0	609,293	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	5,284,618	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,349,740	52.00
53.00	05300	ANESTHESIOLOGY	-3,758,840	181,966	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-117,751	2,161,047	54.00
54.01	05401	ULTRASOUND	0	189,006	54.01
56.00	05600	RADIOISOTOPE	0	506,818	56.00
57.00	05700	CT SCAN	0	427,487	57.00
58.00	05800	MRI	0	112,446	58.00
60.00	06000	LABORATORY	0	2,667,576	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	444,939	62.00
65.00	06500	RESPIRATORY THERAPY	0	699,764	65.00
66.00	06600	PHYSICAL THERAPY	0	661,122	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	223,615	67.00
68.00	06800	SPEECH PATHOLOGY	0	72,461	68.00
69.00	06900	ELECTROCARDIOLOGY	-353,695	2,338,280	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	561,860	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,282,021	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,292,809	73.00
74.00	07400	RENAL DIALYSIS	0	341,320	74.00
76.00	03020	ACUPUNCTURE	0	0	76.00
76.01	03610	SLEEP LAB	-13,650	224,633	76.01
76.03	03951	WOUND CARE	-1,000	144,065	76.03
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-2,378,673	2,507,888	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-15,861,440	66,737,670	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	10,549	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	SENIOR CIRCLE	0	47,712	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	194.00
194.01	07953	MARKETING	0	473,776	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-15,861,440	67,269,707	200.00

RECLASSIFICATIONS

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019

Worksheet A-6

Date/Time Prepared:
9/26/2019 12:56 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,708,635		1.00
	0		0	3,708,635		
	B - OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	29,598		1.00
2.00		0.00	0	0		2.00
	0		0	29,598		
	C - RENTAL AND LEASES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	533,121		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,009,051		2.00
3.00	HOUSEKEEPING	9.00	0	510		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
	0		0	1,542,682		
	D - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	94,830		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	58,248		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,756		3.00
	0		0	157,834		
	E - MARKETING DEPARTMENT					
1.00	MARKETING	194.01	82,840	390,936		1.00
	0		82,840	390,936		
	F - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	532,262		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,282,021		2.00
	0		0	2,814,283		
	G - DRUGS/IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,292,809		1.00
	0		0	2,292,809		
	H - LABOR AND DELIVERY COSTS					
1.00	NURSERY	43.00	132,373	57,179		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	109,100		2.00
	0		132,373	166,279		
	I - PT, OT AND SP COST					
1.00	OCCUPATIONAL THERAPY	67.00	67,791	13,700		1.00
2.00		0.00	0	0		2.00
	TOTALS		67,791	13,700		
	K - MISCELLANEOUS DEPARTMENTS					
1.00	OPERATING ROOM	50.00	439,565	42,608		1.00
2.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	52,699	392,240		2.00
3.00	EMERGENCY	91.00	79,093	205,394		3.00
	0		571,357	640,242		
	M - PORTION OF DIETARY COST TO CAFETERIA					
1.00	CAFETERIA	11.00	0	496,137		1.00
	0		0	496,137		
500.00	Grand Total: Increases		854,361	12,253,135		500.00

RECLASSIFICATIONS

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019

Worksheet A-6

Date/Time Prepared:
9/26/2019 12:56 pm

	Decreases						9/26/2019 12:56 pm
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,708,635	0		1.00
	0		0	3,708,635			
	B - OXYGEN COSTS						
1.00	RESPIRATORY THERAPY	65.00	0	27,811	0		1.00
2.00	WOUND CARE	76.03	0	1,787	0		2.00
	0		0	29,598			
	C - RENTAL AND LEASES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	575,296	10		1.00
2.00	OPERATION OF PLANT	7.00	0	352	10		2.00
3.00	NURSING ADMINISTRATION	13.00	0	18,936	0		3.00
4.00	PHARMACY	15.00	0	48,371	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	53,632	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	17,339	0		6.00
7.00	OPERATING ROOM	50.00	0	382,980	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	3,059	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	263,635	0		9.00
10.00	LABORATORY	60.00	0	22,444	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	61,891	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	12,775	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	74,893	0		13.00
14.00	WOUND CARE	76.03	0	7,079	0		14.00
	0		0	1,542,682			
	D - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	157,834	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	0		0	157,834			
	E - MARKETING DEPARTMENT						
1.00	ADMINISTRATIVE & GENERAL	5.00	82,840	390,936	0		1.00
	0		82,840	390,936			
	F - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,814,283	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	2,814,283			
	G - DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	2,292,809	0		1.00
	0		0	2,292,809			
	H - LABOR AND DELIVERY COSTS						
1.00	ADULTS & PEDIATRICS	30.00	77,681	166,279	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	54,692	0	0		2.00
	0		132,373	166,279			
	I - PT, OT AND SP COST						
1.00	PHYSICAL THERAPY	66.00	12,312	11,843	0		1.00
2.00	SPEECH PATHOLOGY	68.00	55,479	1,857	0		2.00
	TOTALS		67,791	13,700			
	K - MISCELLANEOUS DEPARTMENTS						
1.00	RECOVERY ROOM	51.00	439,565	42,608	0		1.00
2.00	LABORATORY	60.00	52,699	392,240	0		2.00
3.00	AMBULANCE SERVICES	95.00	79,093	205,394	0		3.00
	0		571,357	640,242			
	M - PORTION OF DIETARY COST TO CAFETERIA						
1.00	DIETARY	10.00	0	496,137	0		1.00
	0		0	496,137			
500.00	Grand Total: Decreases		854,361	12,253,135			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019Worksheet A-7
Part I
Date/Time Prepared:
9/26/2019 12:56 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,393,860	0	0	0	0	1.00	
2.00	Land Improvements	564,833	0	0	0	0	2.00	
3.00	Buildings and Fixtures	53,675,900	0	0	0	1,430	3.00	
4.00	Building Improvements	25,478,065	0	0	0	2,597,263	4.00	
5.00	Fixed Equipment	2,507,925	0	0	0	15,908	5.00	
6.00	Movable Equipment	3,430,793	0	0	0	182,481	6.00	
7.00	HIT designated Assets	6,510,822	0	0	0	1,339	7.00	
8.00	Subtotal (sum of lines 1-7)	93,562,198	0	0	0	2,798,421	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	93,562,198	0	0	0	2,798,421	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,393,860	0				1.00	
2.00	Land Improvements	564,833	0				2.00	
3.00	Buildings and Fixtures	53,674,470	0				3.00	
4.00	Building Improvements	22,880,802	0				4.00	
5.00	Fixed Equipment	2,492,017	0				5.00	
6.00	Movable Equipment	3,248,312	0				6.00	
7.00	HIT designated Assets	6,509,483	0				7.00	
8.00	Subtotal (sum of lines 1-7)	90,763,777	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	90,763,777	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019Worksheet A-7
Part II
Date/Time Prepared:
9/26/2019 12:56 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,335,112	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,814,866	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,149,978	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,335,112				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,814,866				2.00
3.00	Total (sum of lines 1-2)	0	4,149,978				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019Worksheet A-7
Part III
Date/Time Prepared:
9/26/2019 12:56 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	78,513,965	0	78,513,965	0.865036	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	12,249,812	0	12,249,812	0.134964	0	2.00
3.00	Total (sum of lines 1-2)	90,763,777	0	90,763,777	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	1,645,368	473,305	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,898,195	1,009,051	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,543,563	1,482,356	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	72,288	94,830	58,248	0	2,344,039	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	18,696	4,756	0	0	2,930,698	2.00
3.00	Total (sum of lines 1-2)	90,984	99,586	58,248	0	5,274,737	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019

Worksheet A-8

Date/Time Prepared:
9/26/2019 12:56 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-59,816	CAP REL COSTS-BLDG & FIXT	1.00	10	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-33,295	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-8,357,550			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	-787,107			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-224,171	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-241	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)	B	0	NURSING ADMINISTRATION	13.00	0	19.00
20.00	Vending machines	B	-629	ADMINISTRATIVE & GENERAL	5.00	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	A	310,256	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-908,045	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELLANEOUS REVENUE	B	1,190	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019

Worksheet A-8

Date/Time Prepared:
9/26/2019 12:56 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.01	INSERVICE EDUCATION	B	-460	NURSING ADMINISTRATION	13.00	0	33.01
33.02	PATIENT PHONE SALARIES AND WAGES	A	-3,265	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	PATIENT PHONE BENEFIT EXPENSE	A	-770	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.03
33.04	PATIENT PHONE DEPRECIATION EXPENSE	A	-6,868	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.04
33.05	PATIENT TV DEPRECIATION EXPENSE	A	-1,758	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.05
33.06	MARKETING EXPENSES	A	-164,211	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	EMPLOYEE GIFTS	A	-17,259	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	PHYSICIAN RECRUITING	A	-147,373	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	LOBBYING EXPENSE	A	-20,290	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	CHARITABLE CONTRIBUTIONS	A	-25,099	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	VOLUNTEERS	A	-807	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	ILLINOIS PROVIDER TAX	A	-5,280,736	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	CRNA COST	A	-47,690	ANESTHESIOLOGY	53.00	0	33.13
33.15	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.15
33.16	SPECIAL EVENTS	A	-16,967	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.18	LATE CHARGES	A	-54,997	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	PATIENT TV CABLE EXPENSE	A	-13,112	OPERATION OF PLANT	7.00	0	33.19
33.20	TRAINING REVENUE	B	-370	NURSING ADMINISTRATION	13.00	0	33.20
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-15,861,440				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019

Worksheet A-8-1

Date/Time Prepared:
9/26/2019 12:56 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	0.00			0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	POOLED ALLOCATION OF NON-CAP	662,238	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	72,288	0	3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	18,696	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL FUNCTIONAL ALLOC	1,206,831	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	2,085,205	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE	158,644	820,599	4.03
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,118,697	2,905,804	5.00

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

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office		
	1.00	2.00	3.00	Name	Percentage of Ownership	5.00

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	B	QUORUM HEALTH C	100.00	QUORUM HEALTH C	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019

Worksheet A-8-1

Date/Time Prepared:
9/26/2019 12:56 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	0	0		1.00
2.00	662,238	0		2.00
3.00	72,288	11		3.00
4.00	18,696	11		4.00
4.01	1,206,831	0		4.01
4.02	-2,085,205	0		4.02
4.03	-661,955	0		4.03
5.00	-787,107			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	HOSPITAL CORPOR		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019

Worksheet A-8-2

Date/Time Prepared:
9/26/2019 12:56 pm

	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	ADULTS & PEDIATRICS	1,653,622	1,653,622	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	128,009	128,009	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	3,711,150	3,711,150	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	117,751	117,751	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	353,695	353,695	0	0	0	5.00
6.00	76.01	SLEEP LAB	13,650	13,650	0	0	0	6.00
7.00	76.03	WOUND CARE	1,000	1,000	0	0	0	7.00
8.00	91.00	EMERGENCY	2,378,673	2,378,673	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			8,357,550	8,357,550	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	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	76.01	SLEEP LAB	0	0	0	0	0	6.00
7.00	76.03	WOUND CARE	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	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	ADULTS & PEDIATRICS	0	0	0	1,653,622		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	128,009		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	3,711,150		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	117,751		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	353,695		5.00
6.00	76.01	SLEEP LAB	0	0	0	13,650		6.00
7.00	76.03	WOUND CARE	0	0	0	1,000		7.00
8.00	91.00	EMERGENCY	0	0	0	2,378,673		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	8,357,550		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,344,039	2,344,039				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,930,698		2,930,698			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,095,306	12,031	15,042	4,122,379		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,324,604	237,478	296,914	578,409	12,437,405	5.00
7.00	00700	OPERATION OF PLANT	2,782,941	509,457	636,962	69,651	3,999,011	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	286,315	4,940	6,176	0	297,431	8.00
9.00	00900	HOUSEKEEPING	1,200,858	13,395	16,748	0	1,231,001	9.00
10.00	01000	DIETARY	1,049,337	36,501	45,636	0	1,131,474	10.00
11.00	01100	CAFETERIA	271,966	41,251	51,575	0	364,792	11.00
13.00	01300	NURSING ADMINISTRATION	1,711,946	56,867	71,100	256,952	2,096,865	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,291,561	23,215	29,025	41,713	4,385,514	14.00
15.00	01500	PHARMACY	1,506,993	21,114	26,398	209,800	1,764,305	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,135,199	34,160	42,710	65,115	1,277,184	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,796,779	368,413	460,618	543,339	5,169,149	30.00
31.00	03100	INTENSIVE CARE UNIT	1,724,354	121,941	152,460	250,215	2,248,970	31.00
43.00	04300	NURSERY	609,293	19,779	24,729	84,852	738,653	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,284,618	204,453	255,623	477,138	6,221,832	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,349,740	47,705	59,644	193,048	1,650,137	52.00
53.00	05300	ANESTHESIOLOGY	181,966	5,926	7,409	0	195,301	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,161,047	72,603	90,774	210,234	2,534,658	54.00
54.01	05401	ULTRASOUND	189,006	20,775	25,974	30,286	266,041	54.01
56.00	05600	RADIOISOTOPE	506,818	6,882	8,604	34,671	556,975	56.00
57.00	05700	CT SCAN	427,487	11,971	14,967	62,097	516,522	57.00
58.00	05800	MRI	112,446	12,718	15,901	17,841	158,906	58.00
60.00	06000	LABORATORY	2,667,576	47,187	58,997	192,248	2,966,008	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	444,939	2,510	3,138	9,282	459,869	62.00
65.00	06500	RESPIRATORY THERAPY	699,764	10,806	13,510	100,757	824,837	65.00
66.00	06600	PHYSICAL THERAPY	661,122	65,183	81,497	103,381	911,183	66.00
67.00	06700	OCCUPATIONAL THERAPY	223,615	1,643	2,055	35,103	262,416	67.00
68.00	06800	SPEECH PATHOLOGY	72,461	926	1,158	11,375	85,920	68.00
69.00	06900	ELECTROCARDIOLOGY	2,338,280	41,729	52,173	204,635	2,636,817	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	561,860	0	0	0	561,860	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,282,021	0	0	0	2,282,021	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,292,809	0	0	0	2,292,809	73.00
74.00	07400	RENAL DIALYSIS	341,320	3,326	4,159	0	348,805	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	224,633	23,464	29,336	0	277,433	76.01
76.03	03951	WOUND CARE	144,065	28,025	35,039	18,902	226,031	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	2,507,888	94,991	118,765	299,639	3,021,283	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	66,737,670	2,203,365	2,754,816	4,100,683	66,399,418	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,732	8,417	0	15,149	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,549	131,462	164,364	0	306,375	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	47,712	2,480	3,101	7,105	60,398	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	473,776	0	0	14,591	488,367	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	67,269,707	2,344,039	2,930,698	4,122,379	67,269,707	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	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	12,437,405					5.00
7.00	00700	OPERATION OF PLANT	907,080	4,906,091				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	67,465	15,290	380,186			8.00
9.00	00900	HOUSEKEEPING	279,223	41,461	0	1,551,685		9.00
10.00	01000	DIETARY	256,648	112,976	0	36,150	1,537,248	10.00
11.00	01100	CAFETERIA	82,744	127,680	0	40,855	0	11.00
13.00	01300	NURSING ADMINISTRATION	475,624	176,015	0	56,321	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	994,749	71,855	0	22,992	0	14.00
15.00	01500	PHARMACY	400,190	65,350	0	20,911	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	289,699	105,732	0	33,832	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,172,497	1,140,303	149,033	364,872	943,745	30.00
31.00	03100	INTENSIVE CARE UNIT	510,125	377,430	35,357	120,769	141,023	31.00
43.00	04300	NURSERY	167,546	61,220	0	19,589	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,411,285	632,820	44,102	202,489	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	374,294	147,655	0	47,246	0	52.00
53.00	05300	ANESTHESIOLOGY	44,299	18,341	0	5,869	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	574,926	224,719	33,076	71,905	0	54.00
54.01	05401	ULTRASOUND	60,345	64,302	0	20,575	0	54.01
56.00	05600	RADIOISOTOPE	126,336	21,301	0	6,816	0	56.00
57.00	05700	CT SCAN	117,161	37,052	0	11,856	0	57.00
58.00	05800	MRI	36,044	39,364	0	12,596	0	58.00
60.00	06000	LABORATORY	672,768	146,052	0	46,734	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	104,310	7,768	0	2,486	0	62.00
65.00	06500	RESPIRATORY THERAPY	187,094	33,446	0	10,702	0	65.00
66.00	06600	PHYSICAL THERAPY	206,680	201,754	14,827	64,557	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	59,523	5,086	0	1,627	0	67.00
68.00	06800	SPEECH PATHOLOGY	19,489	2,867	0	917	0	68.00
69.00	06900	ELECTROCARDIOLOGY	598,099	129,160	20,530	41,328	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	127,444	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	517,622	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	520,069	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	79,118	10,296	0	3,294	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	62,929	72,625	5,323	23,239	0	76.01
76.03	03951	WOUND CARE	51,270	86,743	2,281	27,756	0	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	685,306	294,015	75,657	94,079	38,296	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,240,001	4,470,678	380,186	1,412,362	1,123,064	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,436	20,838	0	6,668	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	69,494	406,899	0	130,199	414,184	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	13,700	7,676	0	2,456	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	110,774	0	0	0	0	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0	0	194.02
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)	12,437,405	4,906,091	380,186	1,551,685	1,537,248	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part I
Date/Time Prepared:
9/26/2019 12:56 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	616,071					11.00
13.00	01300	NURSING ADMINISTRATION	34,745	2,839,570				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,272	0	5,488,382			14.00
15.00	01500	PHARMACY	26,968	0	5,753	2,283,477		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	18,767	0	8,391	0	1,733,605	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	103,243	610,388	211,414	0	113,942	30.00
31.00	03100	INTENSIVE CARE UNIT	36,901	281,092	72,311	0	21,908	31.00
43.00	04300	NURSERY	13,759	95,323	16,840	0	8,017	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	84,031	536,017	966,022	0	288,468	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	33,477	216,870	4,418	0	11,491	52.00
53.00	05300	ANESTHESIOLOGY	0	0	74,041	0	53,825	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	36,584	236,177	3,684	0	39,024	54.00
54.01	05401	ULTRASOUND	5,136	34,024	729	0	15,433	54.01
56.00	05600	RADIOISOTOPE	4,100	38,950	2,585	0	45,595	56.00
57.00	05700	CT SCAN	11,392	69,759	20,612	0	112,511	57.00
58.00	05800	MRI	2,367	20,043	361	0	17,462	58.00
60.00	06000	LABORATORY	55,943	0	359,429	0	302,699	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,071	0	0	0	8,229	62.00
65.00	06500	RESPIRATORY THERAPY	20,057	113,191	36,101	0	44,047	65.00
66.00	06600	PHYSICAL THERAPY	17,203	0	6,552	0	27,624	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,846	0	0	0	9,444	67.00
68.00	06800	SPEECH PATHOLOGY	2,832	0	0	0	3,060	68.00
69.00	06900	ELECTROCARDIOLOGY	36,077	229,886	126,098	0	178,404	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,860,734	0	40,820	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,492,017	0	108,139	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,283,477	107,658	73.00
74.00	07400	RENAL DIALYSIS	0	0	2,782	0	7,165	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	7,463	0	5,676	76.01
76.03	03951	WOUND CARE	3,149	21,235	5,375	0	1,745	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	45,925	336,615	204,643	0	161,219	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	611,845	2,839,570	5,488,355	2,283,477	1,733,605	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	2,113	0	27	0	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	2,113	0	0	0	0	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0	0	194.02
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)	616,071	2,839,570	5,488,382	2,283,477	1,733,605	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part I
Date/Time Prepared:
9/26/2019 12:56 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,978,586	0	9,978,586	30.00
31.00	03100	INTENSIVE CARE UNIT	3,845,886	0	3,845,886	31.00
43.00	04300	NURSERY	1,120,947	0	1,120,947	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,387,066	0	10,387,066	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,485,588	0	2,485,588	52.00
53.00	05300	ANESTHESIOLOGY	391,676	0	391,676	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,754,753	0	3,754,753	54.00
54.01	05401	ULTRASOUND	466,585	0	466,585	54.01
56.00	05600	RADIOISOTOPE	802,658	0	802,658	56.00
57.00	05700	CT SCAN	896,865	0	896,865	57.00
58.00	05800	MRI	287,143	0	287,143	58.00
60.00	06000	LABORATORY	4,549,633	0	4,549,633	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	584,733	0	584,733	62.00
65.00	06500	RESPIRATORY THERAPY	1,269,475	0	1,269,475	65.00
66.00	06600	PHYSICAL THERAPY	1,450,380	0	1,450,380	66.00
67.00	06700	OCCUPATIONAL THERAPY	341,942	0	341,942	67.00
68.00	06800	SPEECH PATHOLOGY	115,085	0	115,085	68.00
69.00	06900	ELECTROCARDIOLOGY	3,996,399	0	3,996,399	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,590,858	0	2,590,858	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,399,799	0	4,399,799	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,204,013	0	5,204,013	73.00
74.00	07400	RENAL DIALYSIS	451,460	0	451,460	74.00
76.00	03020	ACUPUNCTURE	0	0	0	76.00
76.01	03610	SLEEP LAB	454,688	0	454,688	76.01
76.03	03951	WOUND CARE	425,585	0	425,585	76.03
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,957,038	0	4,957,038	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	65,208,841	0	65,208,841	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	46,091	0	46,091	190.00
191.00	19100	RESEARCH	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,327,151	0	1,327,151	192.00
193.00	19300	NONPAID WORKERS	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	86,370	0	86,370	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	194.00
194.01	07953	MARKETING	601,254	0	601,254	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	194.02
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	67,269,707	0	67,269,707	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	12,031	15,042	27,073	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	237,478	296,914	534,392	5.00
7.00	00700	OPERATION OF PLANT	0	509,457	636,962	1,146,419	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,940	6,176	11,116	8.00
9.00	00900	HOUSEKEEPING	0	13,395	16,748	30,143	9.00
10.00	01000	DIETARY	0	36,501	45,636	82,137	10.00
11.00	01100	CAFETERIA	0	41,251	51,575	92,826	11.00
13.00	01300	NURSING ADMINISTRATION	0	56,867	71,100	127,967	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	23,215	29,025	52,240	14.00
15.00	01500	PHARMACY	0	21,114	26,398	47,512	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	34,160	42,710	76,870	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	368,413	460,618	829,031	30.00
31.00	03100	INTENSIVE CARE UNIT	0	121,941	152,460	274,401	31.00
43.00	04300	NURSERY	0	19,779	24,729	44,508	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	204,453	255,623	460,076	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	47,705	59,644	107,349	52.00
53.00	05300	ANESTHESIOLOGY	0	5,926	7,409	13,335	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	72,603	90,774	163,377	54.00
54.01	05401	ULTRASOUND	0	20,775	25,974	46,749	54.01
56.00	05600	RADIOISOTOPE	0	6,882	8,604	15,486	56.00
57.00	05700	CT SCAN	0	11,971	14,967	26,938	57.00
58.00	05800	MRI	0	12,718	15,901	28,619	58.00
60.00	06000	LABORATORY	0	47,187	58,997	106,184	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	2,510	3,138	5,648	62.00
65.00	06500	RESPIRATORY THERAPY	0	10,806	13,510	24,316	65.00
66.00	06600	PHYSICAL THERAPY	0	65,183	81,497	146,680	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,643	2,055	3,698	67.00
68.00	06800	SPEECH PATHOLOGY	0	926	1,158	2,084	68.00
69.00	06900	ELECTROCARDIOLOGY	0	41,729	52,173	93,902	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	3,326	4,159	7,485	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	23,464	29,336	52,800	76.01
76.03	03951	WOUND CARE	0	28,025	35,039	63,064	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	94,991	118,765	213,756	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,203,365	2,754,816	4,958,181	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,732	8,417	15,149	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	131,462	164,364	295,826	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	0	2,480	3,101	5,581	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	0	0	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,344,039	2,930,698	5,274,737	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part II
Date/Time Prepared:
9/26/2019 12:56 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	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	538,184					5.00
7.00	00700	OPERATION OF PLANT	39,250	1,186,127				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,919	3,696	17,731			8.00
9.00	00900	HOUSEKEEPING	12,082	10,024	0	52,249		9.00
10.00	01000	DIETARY	11,105	27,314	0	1,217	121,773	10.00
11.00	01100	CAFETERIA	3,580	30,869	0	1,376	0	11.00
13.00	01300	NURSING ADMINISTRATION	20,581	42,554	0	1,896	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	43,044	17,372	0	774	0	14.00
15.00	01500	PHARMACY	17,317	15,800	0	704	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,536	25,562	0	1,139	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	50,735	275,688	6,952	12,284	74,758	30.00
31.00	03100	INTENSIVE CARE UNIT	22,074	91,250	1,649	4,067	11,171	31.00
43.00	04300	NURSERY	7,250	14,801	0	660	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	61,071	152,995	2,057	6,818	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,196	35,698	0	1,596	0	52.00
53.00	05300	ANESTHESIOLOGY	1,917	4,434	0	198	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,878	54,329	1,543	2,421	0	54.00
54.01	05401	ULTRASOUND	2,611	15,546	0	693	0	54.01
56.00	05600	RADIOISOTOPE	5,467	5,150	0	230	0	56.00
57.00	05700	CT SCAN	5,070	8,958	0	399	0	57.00
58.00	05800	MRI	1,560	9,517	0	424	0	58.00
60.00	06000	LABORATORY	29,111	35,310	0	1,574	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	4,514	1,878	0	84	0	62.00
65.00	06500	RESPIRATORY THERAPY	8,096	8,086	0	360	0	65.00
66.00	06600	PHYSICAL THERAPY	8,943	48,777	691	2,174	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,576	1,230	0	55	0	67.00
68.00	06800	SPEECH PATHOLOGY	843	693	0	31	0	68.00
69.00	06900	ELECTROCARDIOLOGY	25,880	31,226	957	1,392	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,515	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,398	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,504	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	3,424	2,489	0	111	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	2,723	17,558	248	782	0	76.01
76.03	03951	WOUND CARE	2,218	20,972	106	935	0	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	29,654	71,083	3,528	3,168	3,034	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	529,642	1,080,859	17,731	47,557	88,963	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	149	5,038	0	225	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,007	98,374	0	4,384	32,810	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	593	1,856	0	83	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	4,793	0	0	0	0	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0	0	194.02
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)	538,184	1,186,127	17,731	52,249	121,773	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part II
Date/Time Prepared:
9/26/2019 12:56 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	128,651					11.00
13.00	01300	NURSING ADMINISTRATION	7,256	201,942				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,772	0	116,476			14.00
15.00	01500	PHARMACY	5,632	0	122	88,465		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,919	0	178	0	120,632	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	21,559	43,409	4,487	0	7,935	30.00
31.00	03100	INTENSIVE CARE UNIT	7,706	19,991	1,535	0	1,526	31.00
43.00	04300	NURSERY	2,873	6,779	357	0	558	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	17,548	38,120	20,501	0	20,090	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,991	15,423	94	0	800	52.00
53.00	05300	ANESTHESIOLOGY	0	0	1,571	0	3,749	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,640	16,796	78	0	2,718	54.00
54.01	05401	ULTRASOUND	1,072	2,420	15	0	1,075	54.01
56.00	05600	RADIOISOTOPE	856	2,770	55	0	3,175	56.00
57.00	05700	CT SCAN	2,379	4,961	437	0	7,836	57.00
58.00	05800	MRI	494	1,425	8	0	1,216	58.00
60.00	06000	LABORATORY	11,682	0	7,628	0	20,977	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	433	0	0	0	573	62.00
65.00	06500	RESPIRATORY THERAPY	4,188	8,050	766	0	3,068	65.00
66.00	06600	PHYSICAL THERAPY	3,593	0	139	0	1,924	66.00
67.00	06700	OCCUPATIONAL THERAPY	803	0	0	0	658	67.00
68.00	06800	SPEECH PATHOLOGY	591	0	0	0	213	68.00
69.00	06900	ELECTROCARDIOLOGY	7,534	16,349	2,676	0	12,425	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	39,491	0	2,843	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	31,663	0	7,531	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	88,465	7,498	73.00
74.00	07400	RENAL DIALYSIS	0	0	59	0	499	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	158	0	395	76.01
76.03	03951	WOUND CARE	658	1,510	114	0	122	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	9,590	23,939	4,343	0	11,228	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	127,769	201,942	116,475	88,465	120,632	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	441	0	1	0	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	441	0	0	0	0	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0	0	194.02
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)	128,651	201,942	116,476	88,465	120,632	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part II
Date/Time Prepared:
9/26/2019 12:56 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,330,407	0	1,330,407	30.00
31.00	03100	INTENSIVE CARE UNIT	437,014	0	437,014	31.00
43.00	04300	NURSERY	78,343	0	78,343	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	782,410	0	782,410	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	185,410	0	185,410	52.00
53.00	05300	ANESTHESIOLOGY	25,204	0	25,204	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	275,161	0	275,161	54.00
54.01	05401	ULTRASOUND	70,380	0	70,380	54.01
56.00	05600	RADIOISOTOPE	33,417	0	33,417	56.00
57.00	05700	CT SCAN	57,386	0	57,386	57.00
58.00	05800	MRI	43,380	0	43,380	58.00
60.00	06000	LABORATORY	213,729	0	213,729	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	13,191	0	13,191	62.00
65.00	06500	RESPIRATORY THERAPY	57,592	0	57,592	65.00
66.00	06600	PHYSICAL THERAPY	213,600	0	213,600	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,251	0	9,251	67.00
68.00	06800	SPEECH PATHOLOGY	4,530	0	4,530	68.00
69.00	06900	ELECTROCARDIOLOGY	193,685	0	193,685	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	47,849	0	47,849	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	61,592	0	61,592	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	118,467	0	118,467	73.00
74.00	07400	RENAL DIALYSIS	14,067	0	14,067	74.00
76.00	03020	ACUPUNCTURE	0	0	0	76.00
76.01	03610	SLEEP LAB	74,664	0	74,664	76.01
76.03	03951	WOUND CARE	89,823	0	89,823	76.03
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	375,291	0	375,291	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,805,843	0	4,805,843	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	20,561	0	20,561	190.00
191.00	19100	RESEARCH	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	434,401	0	434,401	192.00
193.00	19300	NONPAID WORKERS	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	8,602	0	8,602	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	194.00
194.01	07953	MARKETING	5,330	0	5,330	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	194.02
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,274,737	0	5,274,737	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019

Worksheet B-1

Date/Time Prepared:
9/26/2019 12:56 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	235,363				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		235,363			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,208	1,208	23,404,624		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	23,845	23,845	3,283,840	-12,437,405	5.00
7.00	00700	OPERATION OF PLANT	51,154	51,154	395,443	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	496	496	0	0	8.00
9.00	00900	HOUSEKEEPING	1,345	1,345	0	0	9.00
10.00	01000	DIETARY	3,665	3,665	0	0	10.00
11.00	01100	CAFETERIA	4,142	4,142	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	5,710	5,710	1,458,838	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,331	2,331	236,826	0	14.00
15.00	01500	PHARMACY	2,120	2,120	1,191,129	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,430	3,430	369,689	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	36,992	36,992	3,084,786	0	30.00
31.00	03100	INTENSIVE CARE UNIT	12,244	12,244	1,420,588	0	31.00
43.00	04300	NURSERY	1,986	1,986	481,746	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	20,529	20,529	2,708,936	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,790	4,790	1,096,022	0	52.00
53.00	05300	ANESTHESIOLOGY	595	595	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,290	7,290	1,193,596	0	54.00
54.01	05401	ULTRASOUND	2,086	2,086	171,950	0	54.01
56.00	05600	RADIOISOTOPE	691	691	196,846	0	56.00
57.00	05700	CT SCAN	1,202	1,202	352,552	0	57.00
58.00	05800	MRI	1,277	1,277	101,294	0	58.00
60.00	06000	LABORATORY	4,738	4,738	1,091,483	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	252	252	52,699	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,085	1,085	572,047	0	65.00
66.00	06600	PHYSICAL THERAPY	6,545	6,545	586,944	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	165	165	199,295	0	67.00
68.00	06800	SPEECH PATHOLOGY	93	93	64,581	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,190	4,190	1,161,805	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	334	334	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	2,356	2,356	0	0	76.01
76.03	03951	WOUND CARE	2,814	2,814	107,316	0	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	9,538	9,538	1,701,192	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	221,238	221,238	23,281,443	-12,437,405	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	676	676	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,200	13,200	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	249	249	40,341	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	82,840	0	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0	194.02
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)	2,344,039	2,930,698	4,122,379	12,437,405	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.959250	12.451821	0.176135	0.226826	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			27,073	538,184	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001157	0.009815	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019

Worksheet B-1

Date/Time Prepared:
9/26/2019 12:56 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
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: 14-0184

Period:
From 05/01/2018
To 04/30/2019

Worksheet B-1

Date/Time Prepared:
9/26/2019 12:56 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	159,156				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	496	376,472			8.00
9.00	00900	HOUSEKEEPING	1,345	0	157,315		9.00
10.00	01000	DIETARY	3,665	0	3,665	44,115	10.00
11.00	01100	CAFETERIA	4,142	0	4,142	0	11.00
13.00	01300	NURSING ADMINISTRATION	5,710	0	5,710	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,331	0	2,331	0	14.00
15.00	01500	PHARMACY	2,120	0	2,120	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,430	0	3,430	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	36,992	147,577	36,992	27,083	30.00
31.00	03100	INTENSIVE CARE UNIT	12,244	35,012	12,244	4,047	31.00
43.00	04300	NURSERY	1,986	0	1,986	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	20,529	43,671	20,529	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,790	0	4,790	0	52.00
53.00	05300	ANESTHESIOLOGY	595	0	595	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,290	32,753	7,290	0	54.00
54.01	05401	ULTRASOUND	2,086	0	2,086	0	54.01
56.00	05600	RADIOISOTOPE	691	0	691	0	56.00
57.00	05700	CT SCAN	1,202	0	1,202	0	57.00
58.00	05800	MRI	1,277	0	1,277	0	58.00
60.00	06000	LABORATORY	4,738	0	4,738	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	252	0	252	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,085	0	1,085	0	65.00
66.00	06600	PHYSICAL THERAPY	6,545	14,682	6,545	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	165	0	165	0	67.00
68.00	06800	SPEECH PATHOLOGY	93	0	93	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,190	20,329	4,190	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	334	0	334	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	2,356	5,271	2,356	0	76.01
76.03	03951	WOUND CARE	2,814	2,259	2,814	0	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	9,538	74,918	9,538	1,099	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	145,031	376,472	143,190	32,229	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	676	0	676	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,200	0	13,200	11,886	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	249	0	249	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	0	0	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0	194.02
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)	4,906,091	380,186	1,551,685	1,537,248	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	30.825674	1.009865	9.863554	34.846379	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,186,127	17,731	52,249	121,773	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.452606	0.047098	0.332130	2.760354	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: 14-0184

Period:
From 05/01/2018
To 04/30/2019

Worksheet B-1

Date/Time Prepared:
9/26/2019 12:56 pm

Cost Center Description			NURSING ADMINISTRATION (NURSING WA GES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	
			13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	14,350,676				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,629,097			14.00
15.00	01500	PHARMACY	0	11,141	2,292,809		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	16,251	0	619,055,370	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,084,787	409,437	0	40,693,631	30.00
31.00	03100	INTENSIVE CARE UNIT	1,420,588	140,041	0	7,824,292	31.00
43.00	04300	NURSERY	481,746	32,614	0	2,863,049	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,708,936	1,870,853	0	103,024,182	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,096,021	8,557	0	4,103,848	52.00
53.00	05300	ANESTHESIOLOGY	0	143,391	0	19,223,332	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,193,596	7,134	0	13,937,119	54.00
54.01	05401	ULTRASOUND	171,950	1,412	0	5,511,754	54.01
56.00	05600	RADIOISOTOPE	196,846	5,006	0	16,284,097	56.00
57.00	05700	CT SCAN	352,552	39,918	0	40,182,570	57.00
58.00	05800	MRI	101,294	700	0	6,236,353	58.00
60.00	06000	LABORATORY	0	696,091	0	108,017,373	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	2,938,808	62.00
65.00	06500	RESPIRATORY THERAPY	572,047	69,915	0	15,731,246	65.00
66.00	06600	PHYSICAL THERAPY	0	12,689	0	9,865,741	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,372,855	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,092,955	68.00
69.00	06900	ELECTROCARDIOLOGY	1,161,805	244,208	0	63,715,647	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,603,588	0	14,578,482	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,889,524	0	38,621,173	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,292,809	38,449,189	73.00
74.00	07400	RENAL DIALYSIS	0	5,388	0	2,558,875	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	14,453	0	2,027,156	76.01
76.03	03951	WOUND CARE	107,316	10,409	0	623,345	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	1,701,192	396,324	0	57,578,298	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,350,676	10,629,044	2,292,809	619,055,370	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	0	53	0	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	0	0	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0	194.02
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)	2,839,570	5,488,382	2,283,477	1,733,605	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.197870	0.516354	0.995930	0.002800	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	201,942	116,476	88,465	120,632	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.014072	0.010958	0.038584	0.000195	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019

Worksheet B-1

Date/Time Prepared:
9/26/2019 12:56 pm

Cost Center Description		NURSING ADMINISTRATION (NURSING WA GES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)		
		13.00	14.00	15.00	16.00		
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Worksheet C
Part I
Date/Time Prepared:
9/26/2019 12:56 pm

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COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-0184		Period: From 05/01/2018 To 04/30/2019		Worksheet C Part I Date/Time Prepared: 9/26/2019 12:56 pm		
				Title XVIII			Hospital		PPS	
Cost Center Description				Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
				Inpatient	Outpatient	Total (col. 6 + col. 7)				
				6.00	7.00	8.00				
				9.00				10.00		
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	31,842,841		31,842,841					30.00
31.00	03100	INTENSIVE CARE UNIT	7,824,292		7,824,292					31.00
43.00	04300	NURSERY	2,863,049		2,863,049					43.00
ANCILLARY SERVICE COST CENTERS										
50.00	05000	OPERATING ROOM	35,471,792	67,552,390	103,024,182	0.100822	0.000000			50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,083,185	20,663	4,103,848	0.605673	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	7,589,572	11,633,760	19,223,332	0.020375	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,417,199	10,519,920	13,937,119	0.269407	0.000000			54.00
54.01	05401	ULTRASOUND	1,412,898	4,098,856	5,511,754	0.084653	0.000000			54.01
56.00	05600	RADIOISOTOPE	4,686,864	11,597,233	16,284,097	0.049291	0.000000			56.00
57.00	05700	CT SCAN	9,347,458	30,835,112	40,182,570	0.022320	0.000000			57.00
58.00	05800	MRI	1,180,516	5,055,837	6,236,353	0.046043	0.000000			58.00
60.00	06000	LABORATORY	37,929,872	70,087,501	108,017,373	0.042119	0.000000			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,023,462	1,915,346	2,938,808	0.198969	0.000000			62.00
65.00	06500	RESPIRATORY THERAPY	12,805,439	2,925,807	15,731,246	0.080698	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	5,400,897	4,464,844	9,865,741	0.147012	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	2,239,698	1,133,157	3,372,855	0.101381	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	763,092	329,863	1,092,955	0.105297	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	36,861,961	26,853,686	63,715,647	0.062722	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,607,155	5,971,327	14,578,482	0.177718	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,169,882	15,451,291	38,621,173	0.113922	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,598,654	16,850,535	38,449,189	0.135348	0.000000			73.00
74.00	07400	RENAL DIALYSIS	2,222,745	336,130	2,558,875	0.176429	0.000000			74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000			76.00
76.01	03610	SLEEP LAB	9,720	2,017,436	2,027,156	0.224298	0.000000			76.01
76.03	03951	WOUND CARE	25,854	597,491	623,345	0.682744	0.000000			76.03
OUTPATIENT SERVICE COST CENTERS										
91.00	09100	EMERGENCY	13,833,058	43,745,240	57,578,298	0.086092	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,583,814	6,266,976	8,850,790	0.262567	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS										
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000			96.00
200.00		Subtotal (see instructions)	278,794,969	340,260,401	619,055,370					200.00
201.00		Less Observation Beds								201.00
202.00		Total (see instructions)	278,794,969	340,260,401	619,055,370					202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0184	Period: From 05/01/2018 To 04/30/2019	Worksheet C Part I Date/Time Prepared: 9/26/2019 12:56 pm
Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital
			11.00		PPS
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	0.100822		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.605673		52.00
53.00	05300	ANESTHESIOLOGY	0.020375		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.269407		54.00
54.01	05401	ULTRASOUND	0.084653		54.01
56.00	05600	RADIOISOTOPE	0.049291		56.00
57.00	05700	CT SCAN	0.022320		57.00
58.00	05800	MRI	0.046043		58.00
60.00	06000	LABORATORY	0.042119		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.198969		62.00
65.00	06500	RESPIRATORY THERAPY	0.080698		65.00
66.00	06600	PHYSICAL THERAPY	0.147012		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.101381		67.00
68.00	06800	SPEECH PATHOLOGY	0.105297		68.00
69.00	06900	ELECTROCARDIOLOGY	0.062722		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.177718		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.113922		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.135348		73.00
74.00	07400	RENAL DIALYSIS	0.176429		74.00
76.00	03020	ACUPUNCTURE	0.000000		76.00
76.01	03610	SLEEP LAB	0.224298		76.01
76.03	03951	WOUND CARE	0.682744		76.03
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.086092		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.262567		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019Worksheet C
Part I
Date/Time Prepared:
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			Title XIX		Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
					Total Costs	RCE Disallowance	Total Costs
			1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,978,586		9,978,586	0	9,978,586
31.00	03100	INTENSIVE CARE UNIT	3,845,886		3,845,886	0	3,845,886
43.00	04300	NURSERY	1,120,947		1,120,947	0	1,120,947
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,387,066		10,387,066	0	10,387,066
51.00	05100	RECOVERY ROOM	0		0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,485,588		2,485,588	0	2,485,588
53.00	05300	ANESTHESIOLOGY	391,676		391,676	0	391,676
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,754,753		3,754,753	0	3,754,753
54.01	05401	ULTRASOUND	466,585		466,585	0	466,585
56.00	05600	RADIOISOTOPE	802,658		802,658	0	802,658
57.00	05700	CT SCAN	896,865		896,865	0	896,865
58.00	05800	MRI	287,143		287,143	0	287,143
60.00	06000	LABORATORY	4,549,633		4,549,633	0	4,549,633
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	584,733		584,733	0	584,733
65.00	06500	RESPIRATORY THERAPY	1,269,475	0	1,269,475	0	1,269,475
66.00	06600	PHYSICAL THERAPY	1,450,380	0	1,450,380	0	1,450,380
67.00	06700	OCCUPATIONAL THERAPY	341,942	0	341,942	0	341,942
68.00	06800	SPEECH PATHOLOGY	115,085	0	115,085	0	115,085
69.00	06900	ELECTROCARDIOLOGY	3,996,399		3,996,399	0	3,996,399
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,590,858		2,590,858	0	2,590,858
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,399,799		4,399,799	0	4,399,799
73.00	07300	DRUGS CHARGED TO PATIENTS	5,204,013		5,204,013	0	5,204,013
74.00	07400	RENAL DIALYSIS	451,460		451,460	0	451,460
76.00	03020	ACUPUNCTURE	0		0	0	0
76.01	03610	SLEEP LAB	454,688		454,688	0	454,688
76.03	03951	WOUND CARE	425,585		425,585	0	425,585
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	4,957,038		4,957,038	0	4,957,038
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,323,922		2,323,922	0	2,323,922
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0		0	0	0
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0
200.00		Subtotal (see instructions)	67,532,763	0	67,532,763	0	67,532,763
201.00		Less Observation Beds	2,323,922		2,323,922		2,323,922
202.00		Total (see instructions)	65,208,841	0	65,208,841	0	65,208,841

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019Worksheet C
Part I
Date/Time Prepared:
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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	31,842,841		31,842,841			30.00
31.00	03100	INTENSIVE CARE UNIT	7,824,292		7,824,292			31.00
43.00	04300	NURSERY	2,863,049		2,863,049			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	35,471,792	67,552,390	103,024,182	0.100822	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,083,185	20,663	4,103,848	0.605673	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	7,589,572	11,633,760	19,223,332	0.020375	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,417,199	10,519,920	13,937,119	0.269407	0.000000	54.00
54.01	05401	ULTRASOUND	1,412,898	4,098,856	5,511,754	0.084653	0.000000	54.01
56.00	05600	RADIOISOTOPE	4,686,864	11,597,233	16,284,097	0.049291	0.000000	56.00
57.00	05700	CT SCAN	9,347,458	30,835,112	40,182,570	0.022320	0.000000	57.00
58.00	05800	MRI	1,180,516	5,055,837	6,236,353	0.046043	0.000000	58.00
60.00	06000	LABORATORY	37,929,872	70,087,501	108,017,373	0.042119	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,023,462	1,915,346	2,938,808	0.198969	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	12,805,439	2,925,807	15,731,246	0.080698	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,400,897	4,464,844	9,865,741	0.147012	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,239,698	1,133,157	3,372,855	0.101381	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	763,092	329,863	1,092,955	0.105297	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	36,861,961	26,853,686	63,715,647	0.062722	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,607,155	5,971,327	14,578,482	0.177718	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,169,882	15,451,291	38,621,173	0.113922	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,598,654	16,850,535	38,449,189	0.135348	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,222,745	336,130	2,558,875	0.176429	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	9,720	2,017,436	2,027,156	0.224298	0.000000	76.01
76.03	03951	WOUND CARE	25,854	597,491	623,345	0.682744	0.000000	76.03
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	13,833,058	43,745,240	57,578,298	0.086092	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,583,814	6,266,976	8,850,790	0.262567	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
200.00		Subtotal (see instructions)	278,794,969	340,260,401	619,055,370			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	278,794,969	340,260,401	619,055,370			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019Worksheet C
Part I
Date/Time Prepared:
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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
51.00	05100	RECOVERY ROOM	0.000000			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	05401	ULTRASOUND	0.000000			54.01
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000			62.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
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	03020	ACUPUNCTURE	0.000000			76.00
76.01	03610	SLEEP LAB	0.000000			76.01
76.03	03951	WOUND CARE	0.000000			76.03
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000			96.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019Worksheet D
Part I
Date/Time Prepared:
9/26/2019 12:56 pm

			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	1,330,407	0	1,330,407	10,915	121.89	30.00
31.00	INTENSIVE CARE UNIT	437,014		437,014	1,448	301.81	31.00
43.00	NURSERY	78,343		78,343	1,301	60.22	43.00
200.00	Total (lines 30 through 199)	1,845,764		1,845,764	13,664		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	4,128	503,162				30.00
31.00	INTENSIVE CARE UNIT	714	215,492				31.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	4,842	718,654				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019Worksheet D
Part II
Date/Time Prepared:
9/26/2019 12:56 pm

Cost Center Description			Title XVIII		Hospital	PPS		
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	782,410	103,024,182	0.007594	17,288,658	131,290	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	185,410	4,103,848	0.045180	25,778	1,165	52.00
53.00	05300	ANESTHESIOLOGY	25,204	19,223,332	0.001311	3,606,348	4,728	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	275,161	13,937,119	0.019743	1,762,191	34,791	54.00
54.01	05401	ULTRASOUND	70,380	5,511,754	0.012769	709,668	9,062	54.01
56.00	05600	RADIOISOTOPE	33,417	16,284,097	0.002052	2,166,959	4,447	56.00
57.00	05700	CT SCAN	57,386	40,182,570	0.001428	4,591,312	6,556	57.00
58.00	05800	MRI	43,380	6,236,353	0.006956	535,602	3,726	58.00
60.00	06000	LABORATORY	213,729	108,017,373	0.001979	18,809,127	37,223	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	13,191	2,938,808	0.004489	464,030	2,083	62.00
65.00	06500	RESPIRATORY THERAPY	57,592	15,731,246	0.003661	7,119,778	26,066	65.00
66.00	06600	PHYSICAL THERAPY	213,600	9,865,741	0.021651	3,485,092	75,456	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,251	3,372,855	0.002743	1,455,482	3,992	67.00
68.00	06800	SPEECH PATHOLOGY	4,530	1,092,955	0.004145	251,041	1,041	68.00
69.00	06900	ELECTROCARDIOLOGY	193,685	63,715,647	0.003040	18,604,517	56,558	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	47,849	14,578,482	0.003282	4,908,261	16,109	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	61,592	38,621,173	0.001595	12,468,081	19,887	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	118,467	38,449,189	0.003081	10,403,348	32,053	73.00
74.00	07400	RENAL DIALYSIS	14,067	2,558,875	0.005497	1,437,487	7,902	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	74,664	2,027,156	0.036832	0	0	76.01
76.03	03951	WOUND CARE	89,823	623,345	0.144098	11,591	1,670	76.03
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	375,291	57,578,298	0.006518	7,493,999	48,846	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	309,839	8,850,790	0.035007	1,411,342	49,407	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00		Total (lines 50 through 199)	3,269,918	576,525,188		119,009,692	574,058	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0184		Period: From 05/01/2018 To 04/30/2019		Worksheet D Part III Date/Time Prepared: 9/26/2019 12:56 pm		
					Title XVIII		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	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	10,915	0.00		4,128	30.00	
31.00	03100	INTENSIVE CARE UNIT			0	1,448	0.00		714	31.00	
43.00	04300	NURSERY			0	1,301	0.00		0	43.00	
200.00		Total (lines 30 through 199)			0	13,664			4,842	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: 14-0184

Period:
From 05/01/2018
To 04/30/2019

Worksheet D
Part IV
Date/Time Prepared:
9/26/2019 12:56 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
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	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	76.03
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
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019Worksheet D
Part IV
Date/Time Prepared:
9/26/2019 12:56 pm

				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	103,024,182	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	4,103,848	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	19,223,332	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,937,119	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	5,511,754	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	16,284,097	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	40,182,570	0.000000	57.00
58.00	05800	MRI	0	0	0	6,236,353	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	108,017,373	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	2,938,808	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	15,731,246	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	9,865,741	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,372,855	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,092,955	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	63,715,647	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	14,578,482	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	38,621,173	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	38,449,189	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,558,875	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	2,027,156	0.000000	76.01
76.03	03951	WOUND CARE	0	0	0	623,345	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	57,578,298	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	8,850,790	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0.000000	96.00
200.00		Total (lines 50 through 199)	0	0	0	576,525,188		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019Worksheet D
Part IV
Date/Time Prepared:
9/26/2019 12:56 pm

Cost Center Description		Title XVIII			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	17,288,658	0	23,214,093	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	25,778	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	3,606,348	0	3,845,107	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,762,191	0	3,921,900	0	54.00
54.01	05401	ULTRASOUND	0.000000	709,668	0	1,405,823	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	2,166,959	0	3,474,792	0	56.00
57.00	05700	CT SCAN	0.000000	4,591,312	0	9,755,632	0	57.00
58.00	05800	MRI	0.000000	535,602	0	1,962,035	0	58.00
60.00	06000	LABORATORY	0.000000	18,809,127	0	9,215,350	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	464,030	0	1,625,760	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	7,119,778	0	1,362,598	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	3,485,092	0	228,608	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,455,482	0	108,118	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	251,041	0	4,905	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	18,604,517	0	12,151,416	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	4,908,261	0	2,124,003	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	12,468,081	0	8,042,673	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	10,403,348	0	8,447,320	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	1,437,487	0	218,842	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	690,341	0	76.01
76.03	03951	WOUND CARE	0.000000	11,591	0	192,197	0	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.000000	7,493,999	0	9,742,312	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,411,342	0	2,238,869	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		119,009,692	0	103,972,694	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019Worksheet D
Part V
Date/Time Prepared:
9/26/2019 12:56 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.100822	23,214,093	0	0	2,340,491	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.605673	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.020375	3,845,107	0	0	78,344	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.269407	3,921,900	0	0	1,056,587	54.00
54.01	05401	ULTRASOUND	0.084653	1,405,823	0	0	119,007	54.01
56.00	05600	RADIOISOTOPE	0.049291	3,474,792	0	0	171,276	56.00
57.00	05700	CT SCAN	0.022320	9,755,632	0	0	217,746	57.00
58.00	05800	MRI	0.046043	1,962,035	0	0	90,338	58.00
60.00	06000	LABORATORY	0.042119	9,215,350	0	0	388,141	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.198969	1,625,760	0	0	323,476	62.00
65.00	06500	RESPIRATORY THERAPY	0.080698	1,362,598	0	0	109,959	65.00
66.00	06600	PHYSICAL THERAPY	0.147012	228,608	0	0	33,608	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.101381	108,118	0	0	10,961	67.00
68.00	06800	SPEECH PATHOLOGY	0.105297	4,905	0	0	516	68.00
69.00	06900	ELECTROCARDIOLOGY	0.062722	12,151,416	0	0	762,161	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.177718	2,124,003	0	0	377,474	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.113922	8,042,673	0	0	916,237	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.135348	8,447,320	57,076	0	1,143,328	73.00
74.00	07400	RENAL DIALYSIS	0.176429	218,842	0	0	38,610	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.224298	690,341	0	0	154,842	76.01
76.03	03951	WOUND CARE	0.682744	192,197	0	0	131,221	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.086092	9,742,312	0	0	838,735	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.262567	2,238,869	0	0	587,853	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Subtotal (see instructions)		103,972,694	57,076	0	9,890,911	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		103,972,694	57,076	0	9,890,911	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019Worksheet D
Part V
Date/Time Prepared:
9/26/2019 12:56 pm

			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
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	7,725	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.03	03951	WOUND CARE	0	0		76.03
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	7,725	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	7,725	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0184

Period:

Worksheet D

Component CCN: 14-U184

From 05/01/2018

Part V

To 04/30/2019

Date/Time Prepared:

9/26/2019 12:56 pm

			Title XVIII		Swing Beds - SNF		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.100822	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.605673	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.020375	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.269407	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.084653	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.049291	0	0	0	0	56.00
57.00	05700	CT SCAN	0.022320	0	0	0	0	57.00
58.00	05800	MRI	0.046043	0	0	0	0	58.00
60.00	06000	LABORATORY	0.042119	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.198969	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.080698	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.147012	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.101381	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.105297	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.062722	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.177718	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.113922	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.135348	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.176429	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.224298	0	0	0	0	76.01
76.03	03951	WOUND CARE	0.682744	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.086092	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.262567	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0184

Period:

Worksheet D

Component CCN: 14-U184

From 05/01/2018
To 04/30/2019Part V
Date/Time Prepared:
9/26/2019 12:56 pm

			Title XVIII		Swing Beds - SNF		PPS	
Cost Center Description			Costs					
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
			6.00	7.00				
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0				
51.00	05100	RECOVERY ROOM	0	0				
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0				
53.00	05300	ANESTHESIOLOGY	0	0				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0				
54.01	05401	ULTRASOUND	0	0				
56.00	05600	RADIOISOTOPE	0	0				
57.00	05700	CT SCAN	0	0				
58.00	05800	MRI	0	0				
60.00	06000	LABORATORY	0	0				
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				
65.00	06500	RESPIRATORY THERAPY	0	0				
66.00	06600	PHYSICAL THERAPY	0	0				
67.00	06700	OCCUPATIONAL THERAPY	0	0				
68.00	06800	SPEECH PATHOLOGY	0	0				
69.00	06900	ELECTROCARDIOLOGY	0	0				
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0				
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0				
74.00	07400	RENAL DIALYSIS	0	0				
76.00	03020	ACUPUNCTURE	0	0				
76.01	03610	SLEEP LAB	0	0				
76.03	03951	WOUND CARE	0	0				
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0				
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0				
200.00		Subtotal (see instructions)	0	0				
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0					
202.00		Net Charges (line 200 - line 201)	0	0				

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0184	Period: From 05/01/2018 To 04/30/2019	Worksheet D-1 Date/Time Prepared: 9/26/2019 12:56 pm
Cost Center Description		Title XVIII	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		10,915	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		10,915	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)		8,373	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		4,128	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		9,978,586	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)		9,978,586	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)		9,978,586	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)		914.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,773,859	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		3,773,859	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019

Worksheet D-1

Date/Time Prepared:
9/26/2019 12:56 pm

Cost Center Description			Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospital Program Days	PPS 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		3,845,886	1,448	2,656.00	714	1,896,384	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)						10,891,320	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						16,561,563	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)						718,654	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						574,058	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						1,292,712	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						15,268,851	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)						2,542	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						914.21	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						2,323,922	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019

Worksheet D-1

Date/Time Prepared:
9/26/2019 12:56 pm

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	1,330,407	9,978,586	0.133326	2,323,922	309,839
91.00	Nursing School cost	0	9,978,586	0.000000	2,323,922	0
92.00	Allied health cost	0	9,978,586	0.000000	2,323,922	0
93.00	All other Medical Education	0	9,978,586	0.000000	2,323,922	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0184	Period: From 05/01/2018 To 04/30/2019	Worksheet D-3 Date/Time Prepared: 9/26/2019 12:56 pm	
Cost Center Description		Title XVIII	Hospital	PPS	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		15,908,832	30.00
31.00	03100	INTENSIVE CARE UNIT		3,866,119	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.100822	17,288,658	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.605673	25,778	52.00
53.00	05300	ANESTHESIOLOGY	0.020375	3,606,348	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.269407	1,762,191	54.00
54.01	05401	ULTRASOUND	0.084653	709,668	54.01
56.00	05600	RADIOISOTOPE	0.049291	2,166,959	56.00
57.00	05700	CT SCAN	0.022320	4,591,312	57.00
58.00	05800	MRI	0.046043	535,602	58.00
60.00	06000	LABORATORY	0.042119	18,809,127	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.198969	464,030	62.00
65.00	06500	RESPIRATORY THERAPY	0.080698	7,119,778	65.00
66.00	06600	PHYSICAL THERAPY	0.147012	3,485,092	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.101381	1,455,482	67.00
68.00	06800	SPEECH PATHOLOGY	0.105297	251,041	68.00
69.00	06900	ELECTROCARDIOLOGY	0.062722	18,604,517	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.177718	4,908,261	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.113922	12,468,081	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.135348	10,403,348	73.00
74.00	07400	RENAL DIALYSIS	0.176429	1,437,487	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	76.00
76.01	03610	SLEEP LAB	0.224298	0	76.01
76.03	03951	WOUND CARE	0.682744	11,591	76.03
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.086092	7,493,999	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.262567	1,411,342	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		119,009,692	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)		119,009,692	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0184	Period: From 05/01/2018 To 04/30/2019	Worksheet E Part A Date/Time Prepared: 9/26/2019 12:56 pm
		Title XVIII	Hospital	PPS
				1.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		5,286,048	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		7,887,532	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)		169,164	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		87.04	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		7.81	30.00
31.00	Percentage of Medicaid patient days (see instructions)		33.14	31.00
32.00	Sum of lines 30 and 31		40.95	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.00	33.00
34.00	Disproportionate share adjustment (see instructions)		395,208	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0184	Period: From 05/01/2018 To 04/30/2019	Worksheet E Part A Date/Time Prepared: 9/26/2019 12:56 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	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)	700,249	667,497	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	293,529	387,697	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	681,226		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)	14,419,178		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)		14,419,178	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,085,167	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		15,504,345	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		15,504,345	61.00
62.00	Deductibles billed to program beneficiaries		1,401,520	62.00
63.00	Coinsurance billed to program beneficiaries		26,806	63.00
64.00	Allowable bad debts (see instructions)		498,836	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		324,243	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		477,797	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		14,400,262	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)		-7,541	70.93
70.94	HRR adjustment amount (see instructions)		-278,095	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019Worksheet E
Part A
Date/Time Prepared:
9/26/2019 12:56 pm

		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	0	70.97
70.98	Low Volume Payment-3		0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		14,114,626		71.00
71.01	Sequestration adjustment (see instructions)		282,293		71.01
71.02	Demonstration payment adjustment amount after sequestration		0		71.02
72.00	Interim payments		13,826,673		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)		5,660		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,116,853		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	0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	0	94.00
95.00	Time value of money for operating expenses (see instructions)		0	0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	0	96.00
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000		103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0184	Period: From 05/01/2018 To 04/30/2019	Worksheet E Part B Date/Time Prepared: 9/26/2019 12:56 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		7,725	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		9,890,911	2.00
3.00	OPPS payments		7,788,725	3.00
4.00	Outlier payment (see instructions)		66,896	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)		7,725	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		57,076	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)		57,076	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)		57,076	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		49,351	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)		7,725	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)		7,855,621	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,486,650	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)		6,376,696	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		6,376,696	30.00
31.00	Primary payer payments		147	31.00
32.00	Subtotal (line 30 minus line 31)		6,376,549	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)		411,023	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		267,165	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		404,077	36.00
37.00	Subtotal (see instructions)		6,643,714	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)		0	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)		6,643,714	40.00
40.01	Sequestration adjustment (see instructions)		132,874	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		6,401,874	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		108,966	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: 14-0184

Period:
From 05/01/2018
To 04/30/2019Worksheet E-1
Part I
Date/Time Prepared:
9/26/2019 12:56 pm

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		13,790,773		6,401,874	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	10/26/2018	35,900		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)		35,900		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)		13,826,673		6,401,874	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		5,660		108,966	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		13,832,333		6,510,840	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0184

Period:

Worksheet E-1

Component CCN: 14-U184

From 05/01/2018
To 04/30/2019Part I
Date/Time Prepared:
9/26/2019 12:56 pm

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019Worksheet E-1
Part II
Date/Time Prepared:
9/26/2019 12:56 pm

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-0184 Component CCN: 14-U184	Period: From 05/01/2018 To 04/30/2019	Worksheet E-2 Date/Time Prepared: 9/26/2019 12:56 pm
		Title XVIII	Swing Beds - SNF	PPS
		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)		0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	0	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	0	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	0	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	0	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	0	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	0	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
Comparision of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

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

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019

Worksheet G

Date/Time Prepared:
9/26/2019 12:56 pm

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	-435,370	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	27,158,646	0	0	0	4.00
5.00 Other receivable	0	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-5,782,976	0	0	0	6.00
7.00 Inventory	3,545,823	0	0	0	7.00
8.00 Prepaid expenses	1,094,484	0	0	0	8.00
9.00 Other current assets	603,776	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)	26,184,383	0	0	0	11.00
FIXED ASSETS					
12.00 Land	1,393,860	0	0	0	12.00
13.00 Land improvements	564,833	0	0	0	13.00
14.00 Accumulated depreciation	-436,308	0	0	0	14.00
15.00 Buildings	47,022,538	0	0	0	15.00
16.00 Accumulated depreciation	-14,928,168	0	0	0	16.00
17.00 Leasehold improvements	6,828,821	0	0	0	17.00
18.00 Accumulated depreciation	-3,235,195	0	0	0	18.00
19.00 Fixed equipment	2,492,017	0	0	0	19.00
20.00 Accumulated depreciation	-1,960,037	0	0	0	20.00
21.00 Automobiles and trucks	2,994	0	0	0	21.00
22.00 Accumulated depreciation	-2,994	0	0	0	22.00
23.00 Major movable equipment	18,752,708	0	0	0	23.00
24.00 Accumulated depreciation	-15,296,587	0	0	0	24.00
25.00 Minor equipment depreciable	6,264,060	0	0	0	25.00
26.00 Accumulated depreciation	-5,625,216	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)	41,837,326	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	0	0	0	0	31.00
32.00 Deposits on leases	0	0	0	0	32.00
33.00 Due from owners/officers	0	0	0	0	33.00
34.00 Other assets	12,064,262	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	12,064,262	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	80,085,971	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	7,692,024	0	0	0	37.00
38.00 Salaries, wages, and fees payable	1,618,624	0	0	0	38.00
39.00 Payroll taxes payable	263,082	0	0	0	39.00
40.00 Notes and loans payable (short term)	1,585,340	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	-98,398,036	0	0	0	43.00
44.00 Other current liabilities	1,589,379	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	-85,649,587	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	8,143,079	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	0	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	8,143,079	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	-77,506,508	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	157,592,479				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)	157,592,479	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	80,085,971	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019

Worksheet G-1

Date/Time Prepared:
9/26/2019 12:56 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		131,161,004		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		26,431,475				2.00
3.00	Total (sum of line 1 and line 2)		157,592,479		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)		157,592,479		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)		157,592,479		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: 14-0184

Period:
From 05/01/2018
To 04/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
9/26/2019 12:56 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	34,705,890		34,705,890	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)	34,705,890		34,705,890	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	7,824,292		7,824,292	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)	7,824,292		7,824,292	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	42,530,182		42,530,182	17.00
18.00	Ancillary services	219,847,915	290,248,185	510,096,100	18.00
19.00	Outpatient services	16,416,872	50,012,216	66,429,088	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	ANESTHESIA PROFESSIONAL FEES	909,585	2,043,535	2,953,120	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	279,704,554	342,303,936	622,008,490	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		83,131,147		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		83,131,147		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0184

Period:
From 05/01/2018
To 04/30/2019

Worksheet G-3

Date/Time Prepared:
9/26/2019 12:56 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	622,008,490	1.00
2.00	Less contractual allowances and discounts on patients' accounts	512,727,756	2.00
3.00	Net patient revenues (line 1 minus line 2)	109,280,734	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	83,131,147	4.00
5.00	Net income from service to patients (line 3 minus line 4)	26,149,587	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	281,888	24.00
25.00	Total other income (sum of lines 6-24)	281,888	25.00
26.00	Total (line 5 plus line 25)	26,431,475	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)	26,431,475	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0184	Period: From 05/01/2018 To 04/30/2019	Worksheet L Parts I-III Date/Time Prepared: 9/26/2019 12:56 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,057,439	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		27,728	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)		27.58	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		1,085,167	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