

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: 14-0275	Period: From 07/01/2018 To 06/30/2019	Worksheet S Parts I-III Date/Time Prepared: 9/24/2019 11:40 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 9/24/2019	Time: 11:40 am
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GENESIS MEDICAL CENTER - SILVIS (14-0275) for the cost reporting period beginning 07/01/2018 and ending 06/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) MARK ROGERS

Officer or Administrator of Provider(s)

CFO

Title

09/24/2019 11:40:04 AM

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	167,896	8,724	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
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
200.00	Total	0	167,896	8,724	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: 14-0275		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 9/24/2019 11:40 am		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 801 HOSPITAL ROAD			PO Box:				1.00		
2.00	City: SILVIS			State: IL		Zip Code: 61282-		County: ROCK ISLAND 2.00		
				Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
				1.00	2.00	3.00	4.00	5.00	6.00 V 7.00 XVIII 8.00 XIX	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital			GENESIS MEDICAL CENTER - SILVIS	140275	19340	1	07/01/1966	N P O 3.00	
4.00	Subprovider - IPF								4.00	
5.00	Subprovider - IRF								5.00	
6.00	Subprovider - (Other)								6.00	
7.00	Swing Beds - SNF								7.00	
8.00	Swing Beds - NF								8.00	
9.00	Hospital-Based SNF			ILLINI RESTORATIVE CARE CENTER	145703	19340		09/03/1991	N P N 9.00	
10.00	Hospital-Based NF								10.00	
11.00	Hospital-Based OLTC								11.00	
12.00	Hospital-Based HHA								12.00	
13.00	Separately Certified ASC								13.00	
14.00	Hospital-Based Hospice								14.00	
15.00	Hospital-Based Health Clinic - RHC								15.00	
16.00	Hospital-Based Health Clinic - FQHC								16.00	
17.00	Hospital-Based (CMHC) I								17.00	
18.00	Renal Dialysis								18.00	
19.00	Other								19.00	
								From:	To:	
								1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)							07/01/2018	06/30/2019 20.00	
21.00	Type of Control (see instructions)							2	21.00	
								1.00	2.00 3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					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.				509	276	16	0	1,603	18 24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0275		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 9/24/2019 11:40 am		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
				1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			0	0	0	0	0	25.00	
							Urban/Rural S	Date of Geogr		
							1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						1		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						1		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0		35.00	
							Beginning:	Ending:		
							1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.						0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00	
							Y/N	Y/N		
							1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)						N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)						Y	N	40.00	
							V	XVIII	XIX	
							1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital										
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)						N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.						N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.						N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.						N	N	N	48.00
Teaching Hospitals										
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.						N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.									57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.						N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.						N			59.00
						NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
						1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)						N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0275

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part I
Date/Time Prepared:
9/24/2019 11:40 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0275

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part I
Date/Time Prepared:
9/24/2019 11:40 am

	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	
70.00	Inpatient Psychiatric Facility PPS					
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0
	Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0275	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part I Date/Time Prepared: 9/24/2019 11:40 am		
				1.00		
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00	
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00	
			V	XIX		
			1.00	2.00		
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			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.					109.00
					1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N		110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0275	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part I Date/Time Prepared: 9/24/2019 11:40 am	
			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:	0	0	150,243	
		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		H55790	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0275		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 9/24/2019 11:40 am	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: GENESIS HEALTH SYSTEM		Contractor's Name: WPS		Contractor's Number: 05001				141.00
142.00	Street: 1227 E. RUSHOLME STREET		PO Box:						142.00
143.00	City: DAVENPORT		State: IA		Zip Code: 52803				143.00
									1.00
144.00	Are provider based physicians' costs included in Worksheet A?								Y
									1.00
									2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				N				145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								146.00
									1.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital			N	N	N	N		
156.00	Subprovider - IPF			N	N	N	N		
157.00	Subprovider - IRF			N	N	N	N		
158.00	SUBPROVIDER								
159.00	SNF			N	N	N	N		
160.00	HOME HEALTH AGENCY			N	N	N	N		
161.00	CMHC				N	N	N		
									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
		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
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
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								0.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					07/01/2018	06/30/2019		170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N		0	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0275	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 9/24/2019 11:40 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	11/01/2018
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	09/17/2019	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		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0275

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part II
Date/Time Prepared:
9/24/2019 11:40 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		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.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		Y		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.	MARTIN	ORWITZ		41.00
42.00	Enter the employer/company name of the cost report preparer.	GENESIS HEALTH SYSTEM			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563-421-4175	ORWITZM@GENESISHEALTH.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0275

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part II
Date/Time Prepared:
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		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR, REIMBURSEMENT		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: 14-0275

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
9/24/2019 11:40 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	138	50,370	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)		138	50,370	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	7	2,555	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)		145	52,925	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	44.00	92	33,580		0	19.00
20.00 NURSING FACILITY	45.00	28	10,220		0	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)		265			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: 14-0275

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
9/24/2019 11:40 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,174	408	8,227			1.00
2.00	HMO and other (see instructions)	1,984	1,901				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)	3,174	408	8,227			7.00
8.00	INTENSIVE CARE UNIT	394	31	1,037			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		82	798			13.00
14.00	Total (see instructions)	3,568	521	10,062	0.00	414.68	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	3,164	7,476	25,174	0.00	65.13	19.00
20.00	NURSING FACILITY		0	5,602	0.00	7.54	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	487.35	27.00
28.00	Observation Bed Days		416	1,823			28.00
29.00	Ambulance Trips	2,983					29.00
30.00	Employee discount days (see instruction)			98			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0275

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
9/24/2019 11:40 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,179	716	3,316	1.00
2.00 HMO and other (see instructions)			613	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,179	716	3,316	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	0.00					19.00
20.00 NURSING FACILITY	0.00					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: 14-0275

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part II
Date/Time Prepared:
9/24/2019 11:40 am

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	28,700,354	0	28,700,354	953,727.00	30.09
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	3,024,772	-18,754	3,006,018	134,960.00	22.27
10.00	Excluded area salaries (see instructions)		3,405,808	32,068	3,437,876	176,210.00	19.51
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		428,724	0	428,724	4,376.00	97.97
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		43,856	0	43,856	431.00	101.75
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		7,088,601	0	7,088,601	169,684.00	41.78
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		4,105,900	0	4,105,900		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		1,188,656	0	1,188,656		
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)		1,415,916	0	1,415,916		
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	0	0	0	0.00	0.00
27.00	Administrative & General	5.00	1,423,905	0	1,423,905	16,445.00	86.59

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0275

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part II
Date/Time Prepared:
9/24/2019 11:40 am

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		25,066	0	25,066	238.00	105.32	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	548,728	0	548,728	26,801.00	20.47	30.00
31.00	Laundry & Linen Service	8.00	43,549	-13,314	30,235	2,114.00	14.30	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		545,356	0	545,356	23,486.00	23.22	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		172,653	0	172,653	6,696.00	25.78	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	772,492	0	772,492	22,394.00	34.50	38.00
39.00	Central Services and Supply	14.00	115,891	0	115,891	7,291.00	15.90	39.00
40.00	Pharmacy	15.00	1,754,018	0	1,754,018	39,477.00	44.43	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	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: 14-0275

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part III
Date/Time Prepared:
9/24/2019 11:40 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	29,443,429	0	29,443,429	984,147.00	29.92	1.00
2.00	Excluded area salaries (see instructions)	6,430,580	13,314	6,443,894	311,170.00	20.71	2.00
3.00	Subtotal salaries (line 1 minus line 2)	23,012,849	-13,314	22,999,535	672,977.00	34.18	3.00
4.00	Subtotal other wages & related costs (see inst.)	7,561,181	0	7,561,181	174,491.00	43.33	4.00
5.00	Subtotal wage-related costs (see inst.)	5,521,816	0	5,521,816	0.00	24.01	5.00
6.00	Total (sum of lines 3 thru 5)	36,095,846	-13,314	36,082,532	847,468.00	42.58	6.00
7.00	Total overhead cost (see instructions)	5,401,658	-13,314	5,388,344	144,942.00	37.18	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0275	Period: From 07/01/2018 To 06/30/2019	Worksheet S-3 Part IV Date/Time Prepared: 9/24/2019 11:40 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		366,131	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)		1,590,813	8.02
8.03	Health Insurance (Purchased)		26,166	8.03
9.00	Prescription Drug Plan		532,857	9.00
10.00	Dental, Hearing and Vision Plan		134,386	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		28,534	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		99,982	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		345,708	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		2,076,146	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		43,761	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		21	22.00
23.00	Tuition Reimbursement		50,051	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		5,294,556	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0275

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part V
Date/Time Prepared:
9/24/2019 11:40 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	428,724	5,294,556	1.00
2.00	Hospital	428,724	5,294,556	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	0	0	8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0275

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

Worksheet S-7

Date/Time Prepared:
9/24/2019 11:40 am

		1.00	2.00	3.00	4.00
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N			2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	0 3.00
4.00		RUL	0	0	0 4.00
5.00		RVX	0	0	0 5.00
6.00		RVL	0	0	0 6.00
7.00		RHX	0	0	0 7.00
8.00		RHL	0	0	0 8.00
9.00		RMX	0	0	0 9.00
10.00		RML	0	0	0 10.00
11.00		RLX	0	0	0 11.00
12.00		RUC	157	0	157 12.00
13.00		RUB	144	0	144 13.00
14.00		RUA	246	0	246 14.00
15.00		RVC	677	0	677 15.00
16.00		RVB	550	0	550 16.00
17.00		RVA	903	0	903 17.00
18.00		RHC	104	0	104 18.00
19.00		RHB	58	0	58 19.00
20.00		RHA	68	0	68 20.00
21.00		RMC	0	0	0 21.00
22.00		RMB	33	0	33 22.00
23.00		RMA	15	0	15 23.00
24.00		RLB	0	0	0 24.00
25.00		RLA	0	0	0 25.00
26.00		ES3	0	0	0 26.00
27.00		ES2	0	0	0 27.00
28.00		ES1	0	0	0 28.00
29.00		HE2	0	0	0 29.00
30.00		HE1	0	0	0 30.00
31.00		HD2	0	0	0 31.00
32.00		HD1	6	0	6 32.00
33.00		HC2	0	0	0 33.00
34.00		HC1	11	0	11 34.00
35.00		HB2	0	0	0 35.00
36.00		HB1	28	0	28 36.00
37.00		LE2	0	0	0 37.00
38.00		LE1	11	0	11 38.00
39.00		LD2	0	0	0 39.00
40.00		LD1	0	0	0 40.00
41.00		LC2	9	0	9 41.00
42.00		LC1	1	0	1 42.00
43.00		LB2	0	0	0 43.00
44.00		LB1	0	0	0 44.00
45.00		CE2	0	0	0 45.00
46.00		CE1	0	0	0 46.00
47.00		CD2	6	0	6 47.00
48.00		CD1	54	0	54 48.00
49.00		CC2	0	0	0 49.00
50.00		CC1	4	0	4 50.00
51.00		CB2	0	0	0 51.00
52.00		CB1	37	0	37 52.00
53.00		CA2	0	0	0 53.00
54.00		CA1	19	0	19 54.00
55.00		SE3	0	0	0 55.00
56.00		SE2	0	0	0 56.00
57.00		SE1	0	0	0 57.00
58.00		SSC	0	0	0 58.00
59.00		SSB	0	0	0 59.00
60.00		SSA	0	0	0 60.00
61.00		IB2	0	0	0 61.00
62.00		IB1	0	0	0 62.00
63.00		IA2	0	0	0 63.00
64.00		IA1	0	0	0 64.00
65.00		BB2	0	0	0 65.00
66.00		BB1	0	0	0 66.00
67.00		BA2	0	0	0 67.00
68.00		BA1	0	0	0 68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0275

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

Worksheet S-7

Date/Time Prepared:
9/24/2019 11:40 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	15	0	15	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	7	0	7	78.00
199.00		AAA	1	0	1	199.00
200.00	TOTAL		3,164	0	3,164	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
SNF SERVICES						
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).			19340		201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		2,881,941	39.87	Y	202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		846	0.01	Y	204.00
205.00	Training		1,275	0.02	Y	205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		7,228,404			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0275

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

Worksheet S-10

Date/Time Prepared:
9/24/2019 11:40 am

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.280899	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		14,469,788	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		53,378,982	6.00
7.00	Medicaid cost (line 1 times line 6)		14,994,103	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)		524,315	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)		524,315	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)	4,358,259	0	4,358,259
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,224,231	0	1,224,231
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	1,224,231	0	1,224,231
			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)		8,829,140	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		244,856	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		376,701	27.01
28.00	Non-Medicare bad debt expense (see instructions)		8,452,439	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		2,506,127	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		3,730,358	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		4,254,673	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0275

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

Worksheet A

Date/Time Prepared:
9/24/2019 11:40 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		2,287,888	2,287,888	-44,098	2,243,790	1.00
1.01	00101	NEW CAP RELATED IRC		358,284	358,284	0	358,284	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2,013,634	2,013,634	0	2,013,634	2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC		0	0	0	0	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,136,100	3,136,100	0	3,136,100	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,423,905	22,519,129	23,943,034	0	23,943,034	5.00
7.00	00700	OPERATION OF PLANT	548,728	2,666,241	3,214,969	0	3,214,969	7.00
7.01	00701	OPERATION OF PLANT IRC	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	43,549	53,553	97,102	-29,686	67,416	8.00
9.00	00900	HOUSEKEEPING	0	768,393	768,393	-58,124	710,269	9.00
10.00	01000	DIETARY	0	792,101	792,101	-328,277	463,824	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	772,492	100,170	872,662	0	872,662	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	115,891	166,957	282,848	0	282,848	14.00
15.00	01500	PHARMACY	1,754,018	434,404	2,188,422	0	2,188,422	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,902,632	979,384	5,882,016	-333,981	5,548,035	30.00
31.00	03100	INTENSIVE CARE UNIT	843,435	283,254	1,126,689	0	1,126,689	31.00
43.00	04300	NURSERY	0	0	0	333,981	333,981	43.00
44.00	04400	SKILLED NURSING FACILITY	3,024,772	1,871,671	4,896,443	-83,772	4,812,671	44.00
45.00	04500	NURSING FACILITY	318,560	25,686	344,246	111,412	455,658	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,866,436	1,118,999	2,985,435	0	2,985,435	50.00
53.00	05300	ANESTHESIOLOGY	0	285,844	285,844	0	285,844	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,071,295	581,608	1,652,903	0	1,652,903	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	281,515	5,608,499	5,890,014	0	5,890,014	55.00
57.00	05700	CT SCAN	241,819	119,164	360,983	0	360,983	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	112,627	117,247	229,874	0	229,874	58.00
59.00	05900	CARDIAC CATHETERIZATION	469,859	539,746	1,009,605	0	1,009,605	59.00
60.00	06000	LABORATORY	2,229,152	4,421,496	6,650,648	0	6,650,648	60.00
65.00	06500	RESPIRATORY THERAPY	1,009,413	308,429	1,317,842	0	1,317,842	65.00
66.00	06600	PHYSICAL THERAPY	1,924,735	548,446	2,473,181	0	2,473,181	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,751,943	3,751,943	-2,511,980	1,239,963	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,511,980	2,511,980	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,891,237	2,891,237	0	2,891,237	73.00
76.00	03020	CARDIAC REHAB	322,933	109,629	432,562	0	432,562	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	5,993	359	6,352	0	6,352	90.00
90.01	09001	WOUND CENTER	139,242	231,810	371,052	0	371,052	90.01
91.00	09100	EMERGENCY	2,190,105	4,137,607	6,327,712	0	6,327,712	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	2,942,055	1,261,564	4,203,619	38,816	4,242,435	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,555,161	64,490,476	93,045,637	-393,729	92,651,908	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	45,763	45,763	10,654	56,417	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	16,700	599,754	616,454	4,867	621,321	192.00
192.01	19201	NONREIMBURSABLE	0	0	0	48,794	48,794	192.01
194.00	07950	CROSSTOWN SQUARE	128,493	859,899	988,392	1,137	989,529	194.00
194.02	07954	NONALLOW PHYSICIAN MEALS	0	0	0	58,150	58,150	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	270,127	270,127	194.03
194.04	07951	OUTREACH	0	894	894	0	894	194.04
194.05	07956	RETAIL PHARMACY	0	24,674	24,674	0	24,674	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	28,700,354	66,021,460	94,721,814	0	94,721,814	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0275

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

Worksheet A

Date/Time Prepared:
9/24/2019 11:40 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-129,868	2,113,922	1.00
1.01	00101	NEW CAP RELATED IRC	-44,899	313,385	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	2,013,634	2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC	0	0	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-837,845	2,298,255	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-9,918,166	14,024,868	5.00
7.00	00700	OPERATION OF PLANT	-29,020	3,185,949	7.00
7.01	00701	OPERATION OF PLANT IRC	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	-40,449	26,967	8.00
9.00	00900	HOUSEKEEPING	0	710,269	9.00
10.00	01000	DIETARY	-14,363	449,461	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	872,662	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	306,752	589,600	14.00
15.00	01500	PHARMACY	-11,401	2,177,021	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,048,775	1,048,775	16.00
17.00	01700	SOCIAL SERVICE	65,242	65,242	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-14,099	5,533,936	30.00
31.00	03100	INTENSIVE CARE UNIT	-11,538	1,115,151	31.00
43.00	04300	NURSERY	0	333,981	43.00
44.00	04400	SKILLED NURSING FACILITY	-149,017	4,663,654	44.00
45.00	04500	NURSING FACILITY	0	455,658	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-27,250	2,958,185	50.00
53.00	05300	ANESTHESIOLOGY	-251,119	34,725	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-191,030	1,461,873	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	5,890,014	55.00
57.00	05700	CT SCAN	0	360,983	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	229,874	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,009,605	59.00
60.00	06000	LABORATORY	-678,890	5,971,758	60.00
65.00	06500	RESPIRATORY THERAPY	-57,851	1,259,991	65.00
66.00	06600	PHYSICAL THERAPY	-141,897	2,331,284	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,239,963	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,511,980	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,891,237	73.00
76.00	03020	CARDIAC REHAB	0	432,562	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	6,352	90.00
90.01	09001	WOUND CENTER	-74,207	296,845	90.01
91.00	09100	EMERGENCY	-3,624,778	2,702,934	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-1,330,704	2,911,731	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-16,157,622	76,494,286	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-84,482	-28,065	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-468,024	153,297	192.00
192.01	19201	NONREIMBURSABLE	0	48,794	192.01
194.00	07950	CROSSTOWN SQUARE	-47,605	941,924	194.00
194.02	07954	NONALLOW PHYSICIAN MEALS	0	58,150	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	270,127	194.03
194.04	07951	OUTREACH	-6,568	-5,674	194.04
194.05	07956	RETAIL PHARMACY	0	24,674	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-16,764,301	77,957,513	200.00

RECLASSIFICATIONS

Provider CCN: 14-0275

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

Worksheet A-6

Date/Time Prepared:
9/24/2019 11:40 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
1.00	A - POB DEPRECIATION					1.00
	NONREIMBURSABLE	192.01	0	44,098		
	0		0	44,098		
1.00	B - NURSING HOME OVERHEAD COSTS					1.00
	NURSING FACILITY	45.00	30,307	79,225		
	0		30,307	79,225		
1.00	C - NURSERY COSTS					1.00
	NURSERY	43.00	282,674	51,307		
	0		282,674	51,307		
1.00	D - CHARGEABLE SUPPLIES					1.00
	IMPL. DEV. CHARGED TO PATIENT	72.00	0	2,511,980		
	0		0	2,511,980		
1.00	E - DIETARY COST AND EMPLOYEE MEALS					1.00
	NONALLOW PHYSICIAN MEALS	194.02	0	58,150		
	2.00	NONALLOWABLE GUEST MEALS	194.03	0	270,127	
	0		0	328,277	2.00	
1.00	F - RECLASS HOUSEKEEPING COST					1.00
	AMBULANCE SERVICES	95.00	0	38,816		
	2.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	10,654	
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3,958	3.00	
4.00	NONREIMBURSABLE	192.01	0	4,696	4.00	
	0		0	58,124		
1.00	G - RECLASS LAUNDRY COST					1.00
	SKILLED NURSING FACILITY	44.00	11,553	14,207		
	2.00	NURSING FACILITY	45.00	843	1,037	
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	408	501	3.00	
4.00	CROSSTOWN SQUARE	194.00	510	627	4.00	
	0		13,314	16,372		
500.00	Grand Total: Increases		326,295	3,089,383	500.00	

RECLASSIFICATIONS

Provider CCN: 14-0275

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

Worksheet A-6

Date/Time Prepared:
9/24/2019 11:40 am

	Decreases				Wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other		
	6.00	7.00	8.00	9.00	10.00	
1.00	A - POB DEPRECIATION					
	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	44,098	9	1.00
	0		0	44,098		
1.00	B - NURSING HOME OVERHEAD COSTS					
	SKILLED NURSING FACILITY	44.00	30,307	79,225	0	1.00
	0		30,307	79,225		
1.00	C - NURSERY COSTS					
	ADULTS & PEDIATRICS	30.00	282,674	51,307	0	1.00
	0		282,674	51,307		
1.00	D - CHARGEABLE SUPPLIES					
	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,511,980	0	1.00
	0		0	2,511,980		
1.00	E - DIETARY COST AND EMPLOYEE MEALS					
	DIETARY	10.00	0	58,150	0	1.00
2.00	DIETARY	10.00	0	270,127	0	2.00
	0		0	328,277		
1.00	F - RECLASS HOUSEKEEPING COST					
	HOUSEKEEPING	9.00	0	58,124	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
	0		0	58,124		
1.00	G - RECLASS LAUNDRY COST					
	LAUNDRY & LINEN SERVICE	8.00	13,314	16,372	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
	0		13,314	16,372		
500.00	Grand Total: Decreases		326,295	3,089,383		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0275

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part I
Date/Time Prepared:
9/24/2019 11:40 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,362,122	0	0	0	33,442	1.00	
2.00	Land Improvements	5,304,039	0	0	0	158,394	2.00	
3.00	Buildings and Fixtures	67,203,680	0	0	0	7,810,125	3.00	
4.00	Building Improvements	2,090,594	1	0	1	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	51,014,086	390,121	0	390,121	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	127,974,521	390,122	0	390,122	8,001,961	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	127,974,521	390,122	0	390,122	8,001,961	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,328,680	0				1.00	
2.00	Land Improvements	5,145,645	0				2.00	
3.00	Buildings and Fixtures	59,393,555	0				3.00	
4.00	Building Improvements	2,090,595	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	51,404,207	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	120,362,682	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	120,362,682	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0275

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part II
Date/Time Prepared:
9/24/2019 11:40 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	2,287,888	0	0	0	0	1.00
1.01	NEW CAP RELATED IRC	358,284	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2,013,634	0	0	0	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	4,659,806	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,287,888				1.00
1.01	NEW CAP RELATED IRC	0	358,284				1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	2,013,634				2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	0	0				2.01
3.00	Total (sum of lines 1-2)	0	4,659,806				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0275

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part III
Date/Time Prepared:
9/24/2019 11:40 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	66,629,794	0	66,629,794	0.564497	0	1.00
1.01	NEW CAP RELATED IRC	0	0	0	0.000000	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	51,404,207	0	51,404,207	0.435503	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	118,034,001	0	118,034,001	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	2,243,790	0	1.00
1.01	NEW CAP RELATED IRC	0	0	0	358,284	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	2,013,634	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	4,615,708	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAPS REL COSTS-BLDG & FIXT	-129,868	0	0	0	2,113,922	1.00
1.01	NEW CAP RELATED IRC	-44,899	0	0	0	313,385	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2,013,634	2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	-174,767	0	0	0	4,440,941	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0275

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

Worksheet A-8

Date/Time Prepared:
9/24/2019 11:40 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00				3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0 NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW CAP RELATED IRC (chapter 2)			0 NEW CAP RELATED IRC	1.01	0	1.01
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			0 NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - CAP REL COSTS-MVBLE EQUIP IRC (chapter 2)			0 CAP REL COSTS-MVBLE EQUIP IRC	2.01	0	2.01
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,119,859			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	-556,509			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0 RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0 PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0 *** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0 NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP RELATED IRC			0 NEW CAP RELATED IRC	1.01	0	26.01
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0 NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - CAP REL COSTS-MVBLE EQUIP IRC			0 CAP REL COSTS-MVBLE EQUIP IRC	2.01	0	27.01
28.00	Non-physician Anesthetist			0 *** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0275

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

Worksheet A-8

Date/Time Prepared:
9/24/2019 11:40 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #	Wkst. A-7 Ref.	
				Cost Center				
		1.00	2.00	3.00		4.00	5.00	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***		67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS		30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***		68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0			0.00	0	32.00
33.00	ADMINISTRATION - RENTAL INCOME -3RD	B	-38,431	ADMINISTRATIVE & GENERAL		5.00	0	33.00
34.00	ADMINISTRATION - DISCOUNTS EARNED	B	-8,663	ADMINISTRATIVE & GENERAL		5.00	0	34.00
35.00	ADMINISTRATION - INV INC - GENRAD IM	B	-59,317	ADMINISTRATIVE & GENERAL		5.00	0	35.00
35.03	ADMINISTRATOR - IRC - DISCOUNTS EARN	B	-4	ADMINISTRATIVE & GENERAL		5.00	0	35.03
35.05	ADMINISTRATOR - IRC - MISCELLANEOUS	B	-64	ADMINISTRATIVE & GENERAL		5.00	0	35.05
35.07	ADMINISTRATOR - CS - RENTAL INCOME -	B	-6,276	ADMINISTRATIVE & GENERAL		5.00	0	35.07
35.08	ADMINISTRATOR - CS - RENTAL INCOME -	B	-25,125	ADMINISTRATIVE & GENERAL		5.00	0	35.08
35.11	INFORMATION TECHNOLOGY - MISCELLANEO	B	-3,210	ADMINISTRATIVE & GENERAL		5.00	0	35.11
35.13	MEDICAL STAFF - ILLINI - MISCELLANEO	B	-44,600	ADMINISTRATIVE & GENERAL		5.00	0	35.13
35.14	GRANTS 2 - MISCELLANEOUS REVENUE	B	-2,000	ADMINISTRATIVE & GENERAL		5.00	0	35.14
36.03	SWITCHBOARD - MISCELLANEOUS REVENUE	B	-342	ADMINISTRATIVE & GENERAL		5.00	0	36.03
36.07	SWITCHBOARD- CS - MISCELLANEOUS REVE	B	-7,298	ADMINISTRATIVE & GENERAL		5.00	0	36.07
36.08	PHYSICIAN SUPPORT SVCS - RENTAL INCO	B	-146,080	ADMINISTRATIVE & GENERAL		5.00	0	36.08
36.09	PHYSICIAN SUPPORT SVCS - RENTAL INCO	B	-1,320	ADMINISTRATIVE & GENERAL		5.00	0	36.09
36.10	GROUPS - INTERCOMPANY REVENUE	B	-3,412	OPERATION OF PLANT		7.00	0	36.10
36.11	SECURITY - INTERCOMPANY REVENUE	B	-25,608	OPERATION OF PLANT		7.00	0	36.11
36.13	LAUNDRY - INTERCOMPANY REVENUE	B	-40,449	LAUNDRY & LINEN SERVICE		8.00	0	36.13
36.14	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	36.14
36.15	NUTRITIONAL SERVICES - VENDING SALES	B	-7,954	DIETARY		10.00	0	36.15
36.18	NUTRITIONAL SERVICES - MISCELLANEOUS	B	-20	DIETARY		10.00	0	36.18
36.20	FOOD SERVICE - IRC - MISCELLANEOUS R	B	-4,859	DIETARY		10.00	0	36.20
36.21	FOOD SERVICE - CS - MISCELLANEOUS RE	B	-1,530	DIETARY		10.00	0	36.21
37.00	DISTRIBUTION - MISCELLANEOUS REVENUE	B	-1,190	CENTRAL SERVICES & SUPPLY		14.00	0	37.00
37.06	PHARMACY - INTERCOMPANY REVENUE	B	-11,401	PHARMACY		15.00	0	37.06
37.07	OB SERVICES - MISCELLANEOUS REVENUE	B	-261	ADULTS & PEDIATRICS		30.00	0	37.07
37.09	BIRTH ASSOCIATES - MISCELLANEOUS REV	B	-2,300	ADULTS & PEDIATRICS		30.00	0	37.09
37.10	NURSING FLOOR - IRC MEDICARE - MISCE	B	-20	SKILLED NURSING FACILITY		44.00	0	37.10
37.11	RADIOLOGY - INTERCOMPANY REVENUE	B	-5,324	RADIOLOGY-DIAGNOSTIC		54.00	0	37.11
37.12	GIC-MLI-GENRAD IL - OUTREACH REVENUE	B	-185,706	RADIOLOGY-DIAGNOSTIC		54.00	0	37.12
37.14	LABORATORY - INTERCOMPANY REVENUE	B	-32,384	LABORATORY		60.00	0	37.14
38.00	LABORATORY - MISCELLANEOUS REVENUE	B	-646,506	LABORATORY		60.00	0	38.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0275

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

Worksheet A-8

Date/Time Prepared:
9/24/2019 11:40 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
39.00	PHYSICAL THERAPY - MISCELLANEOUS REV	B	-5,451	PHYSICAL THERAPY	66.00	0	39.00
39.01	P.T. CLINIC -MOLINE HEALTHPLEX - INT	B	-110,755	PHYSICAL THERAPY	66.00	0	39.01
39.02	P.T. CLINIC -MOLINE HEALTHPLEX - MIS	B	-17,140	PHYSICAL THERAPY	66.00	0	39.02
39.03	PHYSICAL THERAPY-MOLINE 7TH ST - INT	B	-5,107	PHYSICAL THERAPY	66.00	0	39.03
39.04	TRAUMA - MISCELLANEOUS REVENUE	B	-51,957	EMERGENCY	91.00	0	39.04
40.00	AMBULANCE - CPE REVENUE	B	-26,885	AMBULANCE SERVICES	95.00	0	40.00
41.00	AMBULANCE - MISCELLANEOUS REVENUE	B	-656,251	AMBULANCE SERVICES	95.00	0	41.00
42.00	AMBULANCE OUTREACH - MISCELLANEOUS R	B	-647,568	AMBULANCE SERVICES	95.00	0	42.00
42.01	OUTSIDE SERVICE SPA - IRC - MISCELLA	B	-18,305	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	42.01
43.00	OUTSIDE SERVICE SPA - CS - MISCELLAN	B	-13,967	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	43.00
43.02	AUXILIARY - GIFT SHOP - MISCELLANEOU	B	-52,210	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	43.02
43.03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.03
43.04	PHYSICIAN OFFICE - RENTAL INCOME -3R	B	-110,667	PHYSICIANS' PRIVATE OFFICES	192.00	0	43.04
43.06	PHYSICIAN OFFICE - RENTAL INCOME - R	B	-128,760	PHYSICIANS' PRIVATE OFFICES	192.00	0	43.06
43.07	2526 41ST ST. - MOLINE - RENTAL INCO	B	-21,105	PHYSICIANS' PRIVATE OFFICES	192.00	0	43.07
43.09	2526 41ST ST. - MOLINE - RENTAL INCO	B	-99,356	PHYSICIANS' PRIVATE OFFICES	192.00	0	43.09
43.10	GENESIS HEALTHPLEX-MOLINE - RENTAL I	B	-108,136	PHYSICIANS' PRIVATE OFFICES	192.00	0	43.10
43.11	NURSING FLOOR - CS - MISCELLANEOUS R	B	-21,765	CROSSTOWN SQUARE	194.00	0	43.11
43.12	ENVIRONMENTAL SVC - OUTREACH - OTHER	B	-6,568	OUTREACH	194.04	0	43.12
43.13	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.13
43.14	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.14
43.15	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.15
44.00	INTEREST - INTEREST EXPENSE - 2010 B	A	-129,868	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	44.00
44.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.01
44.02	INTEREST- IRC - INTEREST EXPENSE - R	A	-44,899	NEW CAP RELATED IRC	1.01	11	44.02
44.03	INTEREST - CS - INTEREST EXPENSE - R	A	-16,607	CROSSTOWN SQUARE	194.00	0	44.03
44.04	ADMINISTRATION - MISCELLANEOUS REVEN	A	-15	ADMINISTRATIVE & GENERAL	5.00	0	44.04
44.05	NURSING FLOOR - IRC MEDICARE - CONTR	A	-40,324	SKILLED NURSING FACILITY	44.00	0	44.05
44.06	ENVIRONMENTAL SVCS - IRC - CONTRACT	A	-39,423	SKILLED NURSING FACILITY	44.00	0	44.06
45.00	ENVIRONMENTAL SVC - CS - CONTRACT FE	A	-1,025	CROSSTOWN SQUARE	194.00	0	45.00
45.01	SECURITY - IRC - CONTRACT FEES- ILLI	A	-17,400	SKILLED NURSING FACILITY	44.00	0	45.01
45.02	SECURITY - CS - CONTRACT FEES- ILLIN	A	-8,208	CROSSTOWN SQUARE	194.00	0	45.02
45.03	ADMINISTRATION - PHYSICIAN PRACTICE	A	-4,544,635	ADMINISTRATIVE & GENERAL	5.00	0	45.03
45.04	PHYSICIAN SUPPORT SVCS	A	-176,974	ADMINISTRATIVE & GENERAL	5.00	0	45.04
45.05	DISTRIBUTION - DONATED INVENTORY	A	-1,230	CENTRAL SERVICES & SUPPLY	14.00	0	45.05
45.06	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.06
45.07	ALCOHOL - IRC	A	-210	SKILLED NURSING FACILITY	44.00	0	45.07
45.08	ADVERTISING & PROMOTIONS	A	-13,800	ADMINISTRATIVE & GENERAL	5.00	0	45.08

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0275

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

Worksheet A-8

Date/Time Prepared:
9/24/2019 11:40 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
45.09	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.09
45.10	ADVERTISING & PROMOTIONS	A	-3,444	PHYSICAL THERAPY	66.00	0	45.10
45.11	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.11
45.12	ADMINISTRATION - PROVIDER TAX ASSESS	A	-2,591,680	ADMINISTRATIVE & GENERAL	5.00	0	45.12
45.13	NURSING ADMIN - IRC - PROVIDER TAX A	A	-51,640	SKILLED NURSING FACILITY	44.00	0	45.13
45.14	ADMINISTRATOR - IRC - PROVIDER TAX A	A	-133,367	ADMINISTRATIVE & GENERAL	5.00	0	45.14
45.15	SELF INSURANCE	A	-837,845	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.15
45.16	LOBBYING	A	-21,732	ADMINISTRATIVE & GENERAL	5.00	0	45.16
45.17	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.17
45.18	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.18
45.19	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.19
45.20	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.20
45.21	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.21
45.22	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.22
45.23	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.23
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-16,764,301				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: 14-0275

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

Worksheet A-8-1

Date/Time Prepared:
9/24/2019 11:40 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	5.00	ADMINISTRATIVE & GENERAL	GHS HOME OFFICE COSTS	11,222,570	13,202,268	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	14.00	CENTRAL SERVICES & SUPPLY	GHS HOME OFFICE COSTS	309,172	0	4.00
4.01	16.00	MEDICAL RECORDS & LIBRARY	GHS HOME OFFICE COSTS	1,048,775	0	4.01
4.02	17.00	SOCIAL SERVICE	GHS HOME OFFICE COSTS	65,242	0	4.02
4.03	0.00			0	0	4.03
4.04	0.00		GHS HOME OFFICE COSTS	0	0	4.04
5.00	0			12,645,759	13,202,268	5.00

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

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
	1.00	2.00	3.00	4.00	5.00
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					
The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.					
This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.					
6.00	C		0.00	GENESIS HEALTH SYSTEM	100.00
7.00			0.00		0.00
8.00			0.00		0.00
9.00			0.00		0.00
10.00			0.00		0.00
100.00	G. Other (financial or non-financial) specify:				

(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: 14-0275

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

Worksheet A-8-1

Date/Time Prepared:
9/24/2019 11:40 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-1,979,698	0		1.00
2.00	0	9		2.00
3.00	0	0		3.00
4.00	309,172	0		4.00
4.01	1,048,775	0		4.01
4.02	65,242	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
5.00	-556,509			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	HOME OFFICE		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: 14-0275

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

Worksheet A-8-2

Date/Time Prepared:
9/24/2019 11:40 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	132,035	113,535	18,500	211,500	182	1.00
2.00	30.00	ADULTS & PEDIATRICS	11,538	11,538	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	11,538	11,538	0	0	0	3.00
4.00	50.00	OPERATING ROOM	27,250	27,250	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	251,119	251,119	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	260,300	0	6.00
7.00	65.00	RESPIRATORY THERAPY	57,851	57,851	0	211,500	0	7.00
8.00	90.01	WOUND CENTER	74,207	74,207	0	0	0	8.00
9.00	91.00	EMERGENCY	3,584,471	3,572,821	11,650	211,500	115	9.00
10.00	95.00	AMBULANCE SERVICES	13,706	0	13,706	211,500	135	10.00
200.00			4,163,715	4,119,859	43,856		432	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	5.00	ADMINISTRATIVE & GENERAL	18,506	925	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	7.00
8.00	90.01	WOUND CENTER	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	11,693	585	0	0	0	9.00
10.00	95.00	AMBULANCE SERVICES	13,727	686	0	0	0	10.00
200.00			43,926	2,196	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	5.00	ADMINISTRATIVE & GENERAL	0	18,506	0	113,535		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	11,538		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	11,538		3.00
4.00	50.00	OPERATING ROOM	0	0	0	27,250		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	251,119		5.00
6.00	60.00	LABORATORY	0	0	0	0		6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	57,851		7.00
8.00	90.01	WOUND CENTER	0	0	0	74,207		8.00
9.00	91.00	EMERGENCY	0	11,693	0	3,572,821		9.00
10.00	95.00	AMBULANCE SERVICES	0	13,727	0	0		10.00
200.00			0	43,926	0	4,119,859		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0275

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
9/24/2019 11:40 am

Cost Center Description			CAPITAL RELATED COSTS					
			Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW CAP RELATED IRC	NEW MVBLE EQUIP		MVBLE EQUIP IRC
0			1.00	1.01	2.00	2.01		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,113,922	2,113,922			1.00	
1.01	00101	NEW CAP RELATED IRC	313,385	0	313,385		1.01	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	2,013,634			2,013,634	2.00	
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC	0		0	0	2.01	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,298,255	5,142	0	0	4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	14,024,868	493,563	0	170,097	5.00	
7.00	00700	OPERATION OF PLANT	3,185,949	199,527	0	42,730	7.00	
7.01	00701	OPERATION OF PLANT IRC	0	0	13,409	0	7.01	
8.00	00800	LAUNDRY & LINEN SERVICE	26,967	21,983	1,082	0	8.00	
9.00	00900	HOUSEKEEPING	710,269	10,027	2,367	5,600	9.00	
10.00	01000	DIETARY	449,461	48,493	0	10,465	10.00	
11.00	01100	CAFETERIA	0	26,923	0	0	11.00	
13.00	01300	NURSING ADMINISTRATION	872,662	7,162	0	57,289	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	589,600	61,413	0	16,562	14.00	
15.00	01500	PHARMACY	2,177,021	42,607	0	47,814	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	1,048,775	25,270	0	0	16.00	
17.00	01700	SOCIAL SERVICE	65,242	10,138	0	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,533,936	394,978	0	198,791	30.00	
31.00	03100	INTENSIVE CARE UNIT	1,115,151	34,343	0	37,740	31.00	
43.00	04300	NURSERY	333,981	19,917	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	4,663,654	0	178,927	17,661	44.00	
45.00	04500	NURSING FACILITY	455,658	0	86,202	0	45.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,958,185	147,903	0	315,344	50.00	
53.00	05300	ANESTHESIOLOGY	34,725	0	0	11,243	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,461,873	81,339	0	197,099	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	5,890,014	0	0	4,323	55.00	
57.00	05700	CT SCAN	360,983	0	0	80,115	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	229,874	1,671	0	118,666	58.00	
59.00	05900	CARDIAC CATHETERIZATION	1,009,605	22,112	0	21,141	59.00	
60.00	06000	LABORATORY	5,971,758	137,591	0	83,431	60.00	
65.00	06500	RESPIRATORY THERAPY	1,259,991	25,821	0	81,295	65.00	
66.00	06600	PHYSICAL THERAPY	2,331,284	31,092	24,147	19,367	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,239,963	0	0	73,238	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,511,980	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	2,891,237	0	0	0	73.00	
76.00	03020	CARDIAC REHAB	432,562	79,888	0	587	76.00	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	6,352	0	0	0	90.00	
90.01	09001	WOUND CENTER	296,845	17,383	0	9,470	90.01	
91.00	09100	EMERGENCY	2,702,934	81,137	0	75,148	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00	
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	2,911,731	65,205	0	312,334	95.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE					113.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	76,494,286	2,092,628	306,134	2,007,550	118.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-28,065	14,646	2,116	84	190.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	153,297	6,648	0	5,104	192.00	
192.01	19201	NONREIMBURSABLE	48,794	0	5,135	0	192.01	
194.00	07950	CROSSTOWN SQUARE	941,924	0	0	896	194.00	
194.02	07954	NONALLOW PHYSICIAN MEALS	58,150	0	0	0	194.02	
194.03	07953	NONALLOWABLE GUEST MEALS	270,127	0	0	0	194.03	
194.04	07951	OUTREACH	-5,674	0	0	0	194.04	
194.05	07956	RETAIL PHARMACY	24,674	0	0	0	194.05	
200.00		Cross Foot Adjustments					200.00	
201.00		Negative Cost Centers		0	0	0	201.00	
202.00		TOTAL (sum lines 118 through 201)	77,957,513	2,113,922	313,385	2,013,634	202.00	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0275

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
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Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT IRC	
			4.00	4A	5.00	7.00	7.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,303,397					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	114,278	14,802,806	14,802,806			5.00
7.00	00700	OPERATION OF PLANT	44,039	3,472,245	813,641	4,285,886		7.00
7.01	00701	OPERATION OF PLANT IRC	0	13,409	3,142	0	16,551	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	2,427	52,459	12,293	66,552	60	8.00
9.00	00900	HOUSEKEEPING	0	728,263	170,652	30,357	131	9.00
10.00	01000	DIETARY	0	508,419	119,136	146,809	0	10.00
11.00	01100	CAFETERIA	0	26,923	6,309	81,508	0	11.00
13.00	01300	NURSING ADMINISTRATION	61,998	999,111	234,119	21,684	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,301	676,876	158,610	185,922	0	14.00
15.00	01500	PHARMACY	140,772	2,408,214	564,310	128,989	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,074,045	251,678	76,504	0	16.00
17.00	01700	SOCIAL SERVICE	0	75,380	17,664	30,691	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	370,776	6,498,481	1,522,763	1,195,760	0	30.00
31.00	03100	INTENSIVE CARE UNIT	67,692	1,254,926	294,063	103,970	0	31.00
43.00	04300	NURSERY	22,687	376,585	88,244	60,297	0	43.00
44.00	04400	SKILLED NURSING FACILITY	240,862	5,101,104	1,195,326	0	9,872	44.00
45.00	04500	NURSING FACILITY	28,459	570,319	133,641	0	4,756	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	149,795	3,571,227	836,835	447,765	0	50.00
53.00	05300	ANESTHESIOLOGY	0	45,968	10,772	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	85,979	1,826,290	427,949	246,247	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	22,594	5,916,931	1,386,497	0	0	55.00
57.00	05700	CT SCAN	19,408	460,506	107,909	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	9,039	359,250	84,182	5,059	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	37,709	1,090,567	255,549	66,941	0	59.00
60.00	06000	LABORATORY	178,905	6,371,685	1,493,058	416,546	0	60.00
65.00	06500	RESPIRATORY THERAPY	81,012	1,448,119	339,333	78,172	0	65.00
66.00	06600	PHYSICAL THERAPY	154,473	2,560,363	599,962	94,129	1,332	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,313,201	307,718	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,511,980	588,625	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,891,237	677,495	0	0	73.00
76.00	03020	CARDIAC REHAB	25,918	538,955	126,292	241,855	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	481	6,833	1,601	0	0	90.00
90.01	09001	WOUND CENTER	11,175	334,873	78,470	52,624	0	90.01
91.00	09100	EMERGENCY	175,771	3,034,990	711,180	245,635	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	236,121	3,525,391	826,094	197,403	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,291,671	76,447,931	14,445,112	4,221,419	16,151	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	-11,219	0	44,340	117	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,373	166,422	38,997	20,127	0	192.00
192.01	19201	NONREIMBURSABLE	0	53,929	12,637	0	283	192.01
194.00	07950	CROSSTOWN SQUARE	10,353	953,173	223,354	0	0	194.00
194.02	07954	NONALLOW PHYSICIAN MEALS	0	58,150	13,626	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	270,127	63,298	0	0	194.03
194.04	07951	OUTREACH	0	-5,674	0	0	0	194.04
194.05	07956	RETAIL PHARMACY	0	24,674	5,782	0	0	194.05
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,303,397	77,957,513	14,802,806	4,285,886	16,551	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0275

Period:
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To 06/30/2019Worksheet B
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Cost Center Description			LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT IRC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE	131,364					8.00
9.00	00900	HOUSEKEEPING	0	929,403				9.00
10.00	01000	DIETARY	0	34,916	809,280			10.00
11.00	01100	CAFETERIA	0	19,386	622,303	756,429		11.00
13.00	01300	NURSING ADMINISTRATION	0	5,157	0	17,515	1,277,586	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,139	44,219	0	5,708	0	14.00
15.00	01500	PHARMACY	0	10,466	0	30,866	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	18,195	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	7,299	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	26,192	284,398	171,145	129,628	1,070,381	30.00
31.00	03100	INTENSIVE CARE UNIT	4,284	24,728	15,832	19,092	163,232	31.00
43.00	04300	NURSERY	187	14,341	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	35,612	0	0	105,917	0	44.00
45.00	04500	NURSING FACILITY	2,941	0	0	12,262	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	21,658	106,495	0	45,746	16,854	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,571	58,567	0	29,663	575	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	7,090	1,724	55.00
57.00	05700	CT SCAN	4,028	0	0	6,537	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	834	1,203	0	2,537	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,251	15,921	0	6,424	1,417	59.00
60.00	06000	LABORATORY	14	58,514	0	73,799	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,417	18,592	0	29,711	94	65.00
66.00	06600	PHYSICAL THERAPY	1,241	26,705	0	47,844	114	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	60	39,062	0	8,391	1,109	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	146	27	90.00
90.01	09001	WOUND CENTER	0	12,516	0	3,870	1,383	90.01
91.00	09100	EMERGENCY	20,069	58,421	0	49,259	20,195	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	46,950	0	117,366	481	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	129,498	906,051	809,280	749,371	1,277,586	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,886	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,866	4,787	0	732	0	192.00
192.01	19201	NONREIMBURSABLE	0	5,679	0	0	0	192.01
194.00	07950	CROSSTOWN SQUARE	0	0	0	6,326	0	194.00
194.02	07954	NONALLOW PHYSICIAN MEALS	0	0	0	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	0	194.03
194.04	07951	OUTREACH	0	0	0	0	0	194.04
194.05	07956	RETAIL PHARMACY	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	131,364	929,403	809,280	756,429	1,277,586	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0275

Period:
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Cost Center Description			CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			14.00	15.00	16.00	17.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT IRC						7.01
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	1,072,474					14.00
15.00	01500	PHARMACY	13,112	3,155,957				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,420,422			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	131,034		17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	60,455	0	78,822	107,138	11,145,163	30.00
31.00	03100	INTENSIVE CARE UNIT	15,493	0	17,066	13,504	1,926,190	31.00
43.00	04300	NURSERY	0	0	6,086	10,392	556,132	43.00
44.00	04400	SKILLED NURSING FACILITY	29,240	0	44,993	0	6,522,064	44.00
45.00	04500	NURSING FACILITY	175	0	5,888	0	729,982	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	123,120	0	112,537	0	5,282,237	50.00
53.00	05300	ANESTHESIOLOGY	6,034	0	16,098	0	78,872	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,289	0	72,308	0	2,676,459	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	29,200	2,051,687	145,101	0	9,538,230	55.00
57.00	05700	CT SCAN	15,631	0	158,504	0	753,115	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	625	0	32,315	0	486,005	58.00
59.00	05900	CARDIAC CATHETERIZATION	16,417	0	65,977	0	1,520,464	59.00
60.00	06000	LABORATORY	4,918	0	223,373	0	8,641,907	60.00
65.00	06500	RESPIRATORY THERAPY	17,226	0	71,552	0	2,004,216	65.00
66.00	06600	PHYSICAL THERAPY	2,664	0	49,153	0	3,383,507	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	218,601	0	27,205	0	1,866,725	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	442,853	0	48,414	0	3,591,872	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,104,270	84,828	0	4,757,830	73.00
76.00	03020	CARDIAC REHAB	878	0	5,190	0	961,792	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	82	0	8,689	90.00
90.01	09001	WOUND CENTER	3,352	0	13,864	0	500,952	90.01
91.00	09100	EMERGENCY	50,826	0	141,066	0	4,331,641	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	15,343	0	0	0	4,729,028	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,072,452	3,155,957	1,420,422	131,034	75,993,072	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	46,124	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	232,931	192.00
192.01	19201	NONREIMBURSABLE	0	0	0	0	72,528	192.01
194.00	07950	CROSSTOWN SQUARE	22	0	0	0	1,182,875	194.00
194.02	07954	NONALLOW PHYSICIAN MEALS	0	0	0	0	71,776	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	333,425	194.03
194.04	07951	OUTREACH	0	0	0	0	-5,674	194.04
194.05	07956	RETAIL PHARMACY	0	0	0	0	30,456	194.05
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,072,474	3,155,957	1,420,422	131,034	77,957,513	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0275

Period:
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To 06/30/2019Worksheet B
Part I
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Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	NEW CAP RELATED IRC			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC			2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT IRC			7.01
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	11,145,163	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,926,190	31.00
43.00	04300	NURSERY	0	556,132	43.00
44.00	04400	SKILLED NURSING FACILITY	0	6,522,064	44.00
45.00	04500	NURSING FACILITY	0	729,982	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	5,282,237	50.00
53.00	05300	ANESTHESIOLOGY	0	78,872	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,676,459	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	9,538,230	55.00
57.00	05700	CT SCAN	0	753,115	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	486,005	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,520,464	59.00
60.00	06000	LABORATORY	0	8,641,907	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,004,216	65.00
66.00	06600	PHYSICAL THERAPY	0	3,383,507	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,866,725	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,591,872	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,757,830	73.00
76.00	03020	CARDIAC REHAB	0	961,792	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	8,689	90.00
90.01	09001	WOUND CENTER	0	500,952	90.01
91.00	09100	EMERGENCY	0	4,331,641	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	4,729,028	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	75,993,072	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	46,124	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	232,931	192.00
192.01	19201	NONREIMBURSABLE	0	72,528	192.01
194.00	07950	CROSSTOWN SQUARE	0	1,182,875	194.00
194.02	07954	NONALLOW PHYSICIAN MEALS	0	71,776	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	333,425	194.03
194.04	07951	OUTREACH	0	-5,674	194.04
194.05	07956	RETAIL PHARMACY	0	30,456	194.05
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	77,957,513	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0275

Period:
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To 06/30/2019Worksheet B
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
			NEW BLDG & FIXT	NEW CAP RELATED IRC	NEW MVBLE EQUIP	MVBLE EQUIP IRC	
		0	1.00	1.01	2.00	2.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP RELATED IRC					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,142	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	333,403	493,563	0	170,097	5.00
7.00	00700	OPERATION OF PLANT	178,183	199,527	0	42,730	7.00
7.01	00701	OPERATION OF PLANT IRC	0	0	13,409	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	21,983	1,082	0	8.00
9.00	00900	HOUSEKEEPING	26,120	10,027	2,367	5,600	9.00
10.00	01000	DIETARY	31,059	48,493	0	10,465	10.00
11.00	01100	CAFETERIA	0	26,923	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	5,141	7,162	0	57,289	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	54,507	61,413	0	16,562	14.00
15.00	01500	PHARMACY	84,153	42,607	0	47,814	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	25,270	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	10,138	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	55,702	394,978	0	198,791	30.00
31.00	03100	INTENSIVE CARE UNIT	12,999	34,343	0	37,740	31.00
43.00	04300	NURSERY	0	19,917	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	87,388	0	178,927	17,661	44.00
45.00	04500	NURSING FACILITY	0	0	86,202	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	73,172	147,903	0	315,344	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	11,243	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,187	81,339	0	197,099	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	33,444	0	0	4,323	55.00
57.00	05700	CT SCAN	762	0	0	80,115	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	9,123	1,671	0	118,666	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,522	22,112	0	21,141	59.00
60.00	06000	LABORATORY	221,604	137,591	0	83,431	60.00
65.00	06500	RESPIRATORY THERAPY	51,949	25,821	0	81,295	65.00
66.00	06600	PHYSICAL THERAPY	304,401	31,092	24,147	19,367	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	73,238	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	74,098	79,888	0	587	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	13	0	0	0	90.00
90.01	09001	WOUND CENTER	42,215	17,383	0	9,470	90.01
91.00	09100	EMERGENCY	25,819	81,137	0	75,148	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	205,749	65,205	0	312,334	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,915,713	2,092,628	306,134	2,007,550	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	23	14,646	2,116	84	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	345,649	6,648	0	5,104	192.00
192.01	19201	NONREIMBURSABLE	0	0	5,135	0	192.01
194.00	07950	CROSSTOWN SQUARE	20,076	0	0	896	194.00
194.02	07954	NONALLOW PHYSICIAN MEALS	0	0	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	194.03
194.04	07951	OUTREACH	0	0	0	0	194.04
194.05	07956	RETAIL PHARMACY	0	0	0	0	194.05
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	2,281,461	2,113,922	313,385	2,013,634	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0275

Period:
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Cost Center Description			Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT IRC	
			2A	4.00	5.00	7.00	7.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,142	5,142				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	997,063	255	997,318			5.00
7.00	00700	OPERATION OF PLANT	420,440	98	54,816	475,354		7.00
7.01	00701	OPERATION OF PLANT IRC	13,409	0	212	0	13,621	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	23,065	5	828	7,381	49	8.00
9.00	00900	HOUSEKEEPING	44,114	0	11,497	3,367	107	9.00
10.00	01000	DIETARY	90,017	0	8,026	16,283	0	10.00
11.00	01100	CAFETERIA	26,923	0	425	9,040	0	11.00
13.00	01300	NURSING ADMINISTRATION	69,592	138	15,773	2,405	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	132,482	21	10,686	20,621	0	14.00
15.00	01500	PHARMACY	174,574	314	38,018	14,306	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	25,270	0	16,956	8,485	0	16.00
17.00	01700	SOCIAL SERVICE	10,138	0	1,190	3,404	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	649,471	832	102,620	132,624	0	30.00
31.00	03100	INTENSIVE CARE UNIT	85,082	151	19,812	11,531	0	31.00
43.00	04300	NURSERY	19,917	51	5,945	6,688	0	43.00
44.00	04400	SKILLED NURSING FACILITY	283,976	537	80,531	0	8,126	44.00
45.00	04500	NURSING FACILITY	86,202	63	9,004	0	3,914	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	536,419	334	56,379	49,662	0	50.00
53.00	05300	ANESTHESIOLOGY	11,243	0	726	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	280,625	192	28,832	27,312	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	37,767	50	93,411	0	0	55.00
57.00	05700	CT SCAN	80,877	43	7,270	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	129,460	20	5,671	561	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	45,775	84	17,217	7,425	0	59.00
60.00	06000	LABORATORY	442,626	399	100,590	46,200	0	60.00
65.00	06500	RESPIRATORY THERAPY	159,065	181	22,861	8,670	0	65.00
66.00	06600	PHYSICAL THERAPY	379,007	345	40,420	10,440	1,096	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	73,238	0	20,732	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	39,657	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	45,644	0	0	73.00
76.00	03020	CARDIAC REHAB	154,573	58	8,508	26,824	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	13	1	108	0	0	90.00
90.01	09001	WOUND CENTER	69,068	25	5,287	5,837	0	90.01
91.00	09100	EMERGENCY	182,104	392	47,913	27,244	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	583,288	527	55,655	21,894	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,322,025	5,116	973,220	468,204	13,292	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,869	0	0	4,918	96	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	357,401	3	2,627	2,232	0	192.00
192.01	19201	NONREIMBURSABLE	5,135	0	851	0	233	192.01
194.00	07950	CROSSTOWN SQUARE	20,972	23	15,048	0	0	194.00
194.02	07954	NONALLOW PHYSICIAN MEALS	0	0	918	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	4,264	0	0	194.03
194.04	07951	OUTREACH	0	0	0	0	0	194.04
194.05	07956	RETAIL PHARMACY	0	0	390	0	0	194.05
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,722,402	5,142	997,318	475,354	13,621	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0275

Period:
From 07/01/2018
To 06/30/2019Worksheet B
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Cost Center Description			LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT IRC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE	31,328					8.00
9.00	00900	HOUSEKEEPING	0	59,085				9.00
10.00	01000	DIETARY	0	2,220	116,546			10.00
11.00	01100	CAFETERIA	0	1,232	89,619	127,239		11.00
13.00	01300	NURSING ADMINISTRATION	0	328	0	2,946	91,182	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	272	2,811	0	960	0	14.00
15.00	01500	PHARMACY	0	665	0	5,192	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,157	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	464	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,246	18,081	24,647	21,802	76,394	30.00
31.00	03100	INTENSIVE CARE UNIT	1,022	1,572	2,280	3,211	11,650	31.00
43.00	04300	NURSERY	45	912	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	8,493	0	0	17,816	0	44.00
45.00	04500	NURSING FACILITY	701	0	0	2,063	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,165	6,770	0	7,695	1,203	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,044	3,723	0	4,990	41	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	1,193	123	55.00
57.00	05700	CT SCAN	961	0	0	1,100	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	199	76	0	427	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	298	1,012	0	1,081	101	59.00
60.00	06000	LABORATORY	3	3,720	0	12,414	0	60.00
65.00	06500	RESPIRATORY THERAPY	338	1,182	0	4,998	7	65.00
66.00	06600	PHYSICAL THERAPY	296	1,698	0	8,048	8	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	14	2,483	0	1,412	79	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	25	2	90.00
90.01	09001	WOUND CENTER	0	796	0	651	99	90.01
91.00	09100	EMERGENCY	4,786	3,714	0	8,286	1,441	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	2,985	0	19,742	34	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,883	57,601	116,546	126,052	91,182	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	819	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	445	304	0	123	0	192.00
192.01	19201	NONREIMBURSABLE	0	361	0	0	0	192.01
194.00	07950	CROSSTOWN SQUARE	0	0	0	1,064	0	194.00
194.02	07954	NONALLOW PHYSICIAN MEALS	0	0	0	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	0	194.03
194.04	07951	OUTREACH	0	0	0	0	0	194.04
194.05	07956	RETAIL PHARMACY	0	0	0	0	0	194.05
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)	31,328	59,085	116,546	127,239	91,182	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0275

Period:
From 07/01/2018
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Cost Center Description			CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			14.00	15.00	16.00	17.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT IRC						7.01
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	167,853					14.00
15.00	01500	PHARMACY	2,052	235,121				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	51,868			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	15,196		17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,462	0	2,879	12,425	1,057,483	30.00
31.00	03100	INTENSIVE CARE UNIT	2,425	0	623	1,566	140,925	31.00
43.00	04300	NURSERY	0	0	222	1,205	34,985	43.00
44.00	04400	SKILLED NURSING FACILITY	4,576	0	1,643	0	405,698	44.00
45.00	04500	NURSING FACILITY	27	0	215	0	102,189	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	19,269	0	4,110	0	687,006	50.00
53.00	05300	ANESTHESIOLOGY	944	0	588	0	13,501	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	984	0	2,641	0	351,384	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,570	152,851	5,300	0	295,265	55.00
57.00	05700	CT SCAN	2,446	0	5,789	0	98,486	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	98	0	1,180	0	137,692	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,569	0	2,410	0	77,972	59.00
60.00	06000	LABORATORY	770	0	8,149	0	614,871	60.00
65.00	06500	RESPIRATORY THERAPY	2,696	0	2,613	0	202,611	65.00
66.00	06600	PHYSICAL THERAPY	417	0	1,795	0	443,570	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	34,213	0	994	0	129,177	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	69,314	0	1,768	0	110,739	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	82,270	3,098	0	131,012	73.00
76.00	03020	CARDIAC REHAB	137	0	190	0	194,278	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	3	0	152	90.00
90.01	09001	WOUND CENTER	525	0	506	0	82,794	90.01
91.00	09100	EMERGENCY	7,955	0	5,152	0	288,987	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	2,401	0	0	0	686,526	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	167,850	235,121	51,868	15,196	6,287,303	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	22,702	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	363,135	192.00
192.01	19201	NONREIMBURSABLE	0	0	0	0	6,580	192.01
194.00	07950	CROSSTOWN SQUARE	3	0	0	0	37,110	194.00
194.02	07954	NONALLOW PHYSICIAN MEALS	0	0	0	0	918	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	4,264	194.03
194.04	07951	OUTREACH	0	0	0	0	0	194.04
194.05	07956	RETAIL PHARMACY	0	0	0	0	390	194.05
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	167,853	235,121	51,868	15,196	6,722,402	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0275

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
9/24/2019 11:40 am

Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	NEW CAP RELATED IRC			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC			2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT IRC			7.01
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,057,483	30.00
31.00	03100	INTENSIVE CARE UNIT	0	140,925	31.00
43.00	04300	NURSERY	0	34,985	43.00
44.00	04400	SKILLED NURSING FACILITY	0	405,698	44.00
45.00	04500	NURSING FACILITY	0	102,189	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	687,006	50.00
53.00	05300	ANESTHESIOLOGY	0	13,501	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	351,384	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	295,265	55.00
57.00	05700	CT SCAN	0	98,486	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	137,692	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	77,972	59.00
60.00	06000	LABORATORY	0	614,871	60.00
65.00	06500	RESPIRATORY THERAPY	0	202,611	65.00
66.00	06600	PHYSICAL THERAPY	0	443,570	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	129,177	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	110,739	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	131,012	73.00
76.00	03020	CARDIAC REHAB	0	194,278	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	152	90.00
90.01	09001	WOUND CENTER	0	82,794	90.01
91.00	09100	EMERGENCY	0	288,987	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	686,526	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	6,287,303	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22,702	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	363,135	192.00
192.01	19201	NONREIMBURSABLE	0	6,580	192.01
194.00	07950	CROSSTOWN SQUARE	0	37,110	194.00
194.02	07954	NONALLOW PHYSICIAN MEALS	0	918	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	4,264	194.03
194.04	07951	OUTREACH	0	0	194.04
194.05	07956	RETAIL PHARMACY	0	390	194.05
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	6,722,402	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0275

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

Worksheet B-1

Date/Time Prepared:
9/24/2019 11:40 am

Cost Center Description			CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			NEW BLDG & FIXT (SQUARE FEET)	NEW CAP RELATED IRC (SQUARE FEET IRC)	NEW MVBLE EQUIP (DOLLAR VALUE)	MVBLE EQUIP IRC (DOLLAR VALUE)		
			1.00	1.01	2.00	2.01	4.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	230,211				1.00	
1.01	00101	NEW CAP RELATED IRC	0	52,420			1.01	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			1,931,077		2.00	
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC			0	0	2.01	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	560	0	0	28,700,355	4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	53,750	0	163,123	1,423,905	5.00	
7.00	00700	OPERATION OF PLANT	21,729		40,978	548,728	7.00	
7.01	00701	OPERATION OF PLANT IRC	0	2,243	0	0	7.01	
8.00	00800	LAUNDRY & LINEN SERVICE	2,394	181	0	30,236	8.00	
9.00	00900	HOUSEKEEPING	1,092	396	5,370	0	9.00	
10.00	01000	DIETARY	5,281	0	10,036	0	10.00	
11.00	01100	CAFETERIA	2,932	0	0	0	11.00	
13.00	01300	NURSING ADMINISTRATION	780	0	54,940	772,492	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	6,688	0	15,883	115,891	14.00	
15.00	01500	PHARMACY	4,640	0	45,854	1,754,018	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	2,752	0	0	0	16.00	
17.00	01700	SOCIAL SERVICE	1,104	0	0	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	43,014	0	190,641	4,619,958	30.00	
31.00	03100	INTENSIVE CARE UNIT	3,740	0	36,193	843,435	31.00	
43.00	04300	NURSERY	2,169	0	0	282,674	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	29,929	16,937	3,001,133	44.00	
45.00	04500	NURSING FACILITY	0	14,419	0	354,595	45.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	16,107	0	302,415	1,866,436	50.00	
53.00	05300	ANESTHESIOLOGY	0	0	10,782	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,858	0	189,018	1,071,295	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	4,146	281,515	55.00	
57.00	05700	CT SCAN	0	0	76,830	241,819	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	182	0	113,801	112,627	58.00	
59.00	05900	CARDIAC CATHETERIZATION	2,408	0	20,274	469,859	59.00	
60.00	06000	LABORATORY	14,984	0	80,010	2,229,152	60.00	
65.00	06500	RESPIRATORY THERAPY	2,812	0	77,962	1,009,413	65.00	
66.00	06600	PHYSICAL THERAPY	3,386	4,039	18,573	1,924,735	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	70,235	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00	
76.00	03020	CARDIAC REHAB	8,700	0	563	322,933	76.00	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	5,993	90.00	
90.01	09001	WOUND CENTER	1,893	0	9,082	139,242	90.01	
91.00	09100	EMERGENCY	8,836	0	72,067	2,190,105	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00	
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	7,101	0	299,529	2,942,055	95.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE					113.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	227,892	51,207	1,925,242	28,554,244	118.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,595	354	81	0	190.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	724	0	4,895	17,108	192.00	
192.01	19201	NONREIMBURSABLE	0	859	0	0	192.01	
194.00	07950	CROSSTOWN SQUARE	0	0	859	129,003	194.00	
194.02	07954	NONALLOW PHYSICIAN MEALS	0	0	0	0	194.02	
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	194.03	
194.04	07951	OUTREACH	0	0	0	0	194.04	
194.05	07956	RETAIL PHARMACY	0	0	0	0	194.05	
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)	2,113,922	313,385	2,013,634	2,303,397	202.00	
203.00		Unit cost multiplier (Wkst. B, Part I)	9.182541	5.978348	1.042752	0.080257	203.00	
204.00		Cost to be allocated (per Wkst. B, Part II)				5,142	204.00	
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000179	205.00	
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0275

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

Worksheet B-1

Date/Time Prepared:
9/24/2019 11:40 am

Cost Center Description			CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			NEW BLDG & FIXT (SQUARE FEET)	NEW CAP RELATED IRC (SQUARE FEET IRC)	NEW MVBLE EQUIP (DOLLAR VALUE)	MVBLE EQUIP IRC (DOLLAR VALUE)		
			1.00	1.01	2.00	2.01	4.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0275

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

Worksheet B-1

Date/Time Prepared:
9/24/2019 11:40 am

Cost Center Description		Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT IRC (SQUARE FEET IRC)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		5A	5.00	7.00	7.01	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP RELATED IRC					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-14,802,806	63,171,600			5.00
7.00	00700	OPERATION OF PLANT	0	3,472,245	154,172		7.00
7.01	00701	OPERATION OF PLANT IRC	0	13,409	0	50,177	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	52,459	2,394	181	571,087
9.00	00900	HOUSEKEEPING	0	728,263	1,092	396	0
10.00	01000	DIETARY	0	508,419	5,281	0	0
11.00	01100	CAFETERIA	0	26,923	2,932	0	0
13.00	01300	NURSING ADMINISTRATION	0	999,111	780	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	676,876	6,688	0	4,951
15.00	01500	PHARMACY	0	2,408,214	4,640	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,074,045	2,752	0	0
17.00	01700	SOCIAL SERVICE	0	75,380	1,104	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	6,498,481	43,014	0	113,867
31.00	03100	INTENSIVE CARE UNIT	0	1,254,926	3,740	0	18,622
43.00	04300	NURSERY	0	376,585	2,169	0	812
44.00	04400	SKILLED NURSING FACILITY	0	5,101,104	0	29,929	154,829
45.00	04500	NURSING FACILITY	0	570,319	0	14,419	12,784
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	3,571,227	16,107	0	94,155
53.00	05300	ANESTHESIOLOGY	0	45,968	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,826,290	8,858	0	37,260
55.00	05500	RADIOLOGY-THERAPEUTIC	0	5,916,931	0	0	0
57.00	05700	CT SCAN	0	460,506	0	0	17,511
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	359,250	182	0	3,625
59.00	05900	CARDIAC CATHETERIZATION	0	1,090,567	2,408	0	5,437
60.00	06000	LABORATORY	0	6,371,685	14,984	0	59
65.00	06500	RESPIRATORY THERAPY	0	1,448,119	2,812	0	6,161
66.00	06600	PHYSICAL THERAPY	0	2,560,363	3,386	4,039	5,396
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,313,201	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,511,980	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,891,237	0	0	0
76.00	03020	CARDIAC REHAB	0	538,955	8,700	0	261
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	6,833	0	0	0
90.01	09001	WOUND CENTER	0	334,873	1,893	0	0
91.00	09100	EMERGENCY	0	3,034,990	8,836	0	87,246
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	3,525,391	7,101	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-14,802,806	61,645,125	151,853	48,964	562,976
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,219	0	1,595	354	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	166,422	724	0	8,111
192.01	19201	NONREIMBURSABLE	0	53,929	0	859	0
194.00	07950	CROSSTOWN SQUARE	0	953,173	0	0	0
194.02	07954	NONALLOW PHYSICIAN MEALS	0	58,150	0	0	0
194.03	07953	NONALLOWABLE GUEST MEALS	0	270,127	0	0	0
194.04	07951	OUTREACH	5,674	0	0	0	0
194.05	07956	RETAIL PHARMACY	0	24,674	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)		14,802,806	4,285,886	16,551	131,364
203.00		Unit cost multiplier (Wkst. B, Part I)		0.234327	27.799380	0.329852	0.230024
204.00		Cost to be allocated (per Wkst. B, Part II)		997,318	475,354	13,621	31,328
205.00		Unit cost multiplier (Wkst. B, Part II)		0.015787	3.083271	0.271459	0.054857
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0275

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

Worksheet B-1

Date/Time Prepared:
9/24/2019 11:40 am

Cost Center Description			HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT IRC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	140,569					9.00
10.00	01000	DIETARY	5,281	125,181				10.00
11.00	01100	CAFETERIA	2,932	96,259	46,514			11.00
13.00	01300	NURSING ADMINISTRATION	780	0	1,077	191,178		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,688	0	351	0	6,083,362	14.00
15.00	01500	PHARMACY	1,583	0	1,898	0	74,373	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,752	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,104	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	43,014	26,473	7,971	160,172	342,917	30.00
31.00	03100	INTENSIVE CARE UNIT	3,740	2,449	1,174	24,426	87,880	31.00
43.00	04300	NURSERY	2,169	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	6,513	0	165,858	44.00
45.00	04500	NURSING FACILITY	0	0	754	0	990	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	16,107	0	2,813	2,522	698,372	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	34,225	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,858	0	1,824	86	35,671	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	436	258	165,629	55.00
57.00	05700	CT SCAN	0	0	402	0	88,665	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	182	0	156	0	3,547	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,408	0	395	212	93,122	59.00
60.00	06000	LABORATORY	8,850	0	4,538	0	27,896	60.00
65.00	06500	RESPIRATORY THERAPY	2,812	0	1,827	14	97,712	65.00
66.00	06600	PHYSICAL THERAPY	4,039	0	2,942	17	15,113	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,239,963	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	2,511,980	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	5,908	0	516	166	4,982	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	9	4	0	90.00
90.01	09001	WOUND CENTER	1,893	0	238	207	19,014	90.01
91.00	09100	EMERGENCY	8,836	0	3,029	3,022	288,298	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	7,101	0	7,217	72	87,032	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	137,037	125,181	46,080	191,178	6,083,239	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,949	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	724	0	45	0	0	192.00
192.01	19201	NONREIMBURSABLE	859	0	0	0	0	192.01
194.00	07950	CROSSTOWN SQUARE	0	0	389	0	123	194.00
194.02	07954	NONALLOW PHYSICIAN MEALS	0	0	0	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	0	194.03
194.04	07951	OUTREACH	0	0	0	0	0	194.04
194.05	07956	RETAIL PHARMACY	0	0	0	0	0	194.05
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)	929,403	809,280	756,429	1,277,586	1,072,474	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.611721	6.464879	16.262394	6.682704	0.176296	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	59,085	116,546	127,239	91,182	167,853	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.420327	0.931020	2.735499	0.476948	0.027592	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: 14-0275

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

Worksheet B-1

Date/Time Prepared:
9/24/2019 11:40 am

Cost Center Description			PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)		
			15.00	16.00	17.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP RELATED IRC					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT IRC					7.01
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	8,263,040				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	255,586,480			16.00
17.00	01700	SOCIAL SERVICE	0	0	10,062		17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	14,181,759	8,227		30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,070,568	1,037		31.00
43.00	04300	NURSERY	0	1,094,969	798		43.00
44.00	04400	SKILLED NURSING FACILITY	0	8,095,089	0		44.00
45.00	04500	NURSING FACILITY	0	1,059,317	0		45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	20,247,836	0		50.00
53.00	05300	ANESTHESIOLOGY	0	2,896,381	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,009,753	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,371,803	26,106,621	0		55.00
57.00	05700	CT SCAN	0	28,518,233	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	5,814,222	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	11,870,622	0		59.00
60.00	06000	LABORATORY	0	40,212,508	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	12,873,674	0		65.00
66.00	06600	PHYSICAL THERAPY	0	8,843,690	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,894,688	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	8,710,601	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,891,237	15,262,240	0		73.00
76.00	03020	CARDIAC REHAB	0	933,768	0		76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	14,753	0		90.00
90.01	09001	WOUND CENTER	0	2,494,455	0		90.01
91.00	09100	EMERGENCY	0	25,380,733	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		95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,263,040	255,586,480	10,062		118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
192.01	19201	NONREIMBURSABLE	0	0	0		192.01
194.00	07950	CROSSTOWN SQUARE	0	0	0		194.00
194.02	07954	NONALLOW PHYSICIAN MEALS	0	0	0		194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0		194.03
194.04	07951	OUTREACH	0	0	0		194.04
194.05	07956	RETAIL PHARMACY	0	0	0		194.05
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,155,957	1,420,422	131,034		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.381937	0.005558	13.022660		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	235,121	51,868	15,196		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.028455	0.000203	1.510237		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0275

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
9/24/2019 11:40 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE		Total Costs
						Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,145,163		11,145,163	0	11,145,163	30.00
31.00	03100	INTENSIVE CARE UNIT	1,926,190		1,926,190	0	1,926,190	31.00
43.00	04300	NURSERY	556,132		556,132	0	556,132	43.00
44.00	04400	SKILLED NURSING FACILITY	6,522,064		6,522,064	0	6,522,064	44.00
45.00	04500	NURSING FACILITY	729,982		729,982	0	729,982	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,282,237		5,282,237	0	5,282,237	50.00
53.00	05300	ANESTHESIOLOGY	78,872		78,872	0	78,872	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,676,459		2,676,459	0	2,676,459	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	9,538,230		9,538,230	0	9,538,230	55.00
57.00	05700	CT SCAN	753,115		753,115	0	753,115	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	486,005		486,005	0	486,005	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,520,464		1,520,464	0	1,520,464	59.00
60.00	06000	LABORATORY	8,641,907		8,641,907	0	8,641,907	60.00
65.00	06500	RESPIRATORY THERAPY	2,004,216	0	2,004,216	0	2,004,216	65.00
66.00	06600	PHYSICAL THERAPY	3,383,507	0	3,383,507	0	3,383,507	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,866,725		1,866,725	0	1,866,725	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,591,872		3,591,872	0	3,591,872	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,757,830		4,757,830	0	4,757,830	73.00
76.00	03020	CARDIAC REHAB	961,792		961,792	0	961,792	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	8,689		8,689	0	8,689	90.00
90.01	09001	WOUND CENTER	500,952		500,952	0	500,952	90.01
91.00	09100	EMERGENCY	4,331,641		4,331,641	0	4,331,641	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,021,652		2,021,652	0	2,021,652	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	4,729,028		4,729,028	0	4,729,028	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	78,014,724	0	78,014,724	0	78,014,724	200.00
201.00		Less Observation Beds	2,021,652		2,021,652		2,021,652	201.00
202.00		Total (see instructions)	75,993,072	0	75,993,072	0	75,993,072	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0275

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
9/24/2019 11:40 am

			Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	14,181,759		14,181,759		30.00
31.00	03100	INTENSIVE CARE UNIT	3,070,568		3,070,568		31.00
43.00	04300	NURSERY	1,094,969		1,094,969		43.00
44.00	04400	SKILLED NURSING FACILITY	8,095,089		8,095,089		44.00
45.00	04500	NURSING FACILITY	1,059,317		1,059,317		45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,095,643	14,152,193	20,247,836	0.260879	0.000000
53.00	05300	ANESTHESIOLOGY	951,477	1,944,904	2,896,381	0.027231	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,588,460	11,421,293	13,009,753	0.205727	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	215,241	25,891,380	26,106,621	0.365357	0.000000
57.00	05700	CT SCAN	5,056,612	23,461,621	28,518,233	0.026408	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	369,178	5,445,044	5,814,222	0.083589	0.000000
59.00	05900	CARDIAC CATHETERIZATION	4,064,529	7,806,093	11,870,622	0.128086	0.000000
60.00	06000	LABORATORY	8,597,277	31,615,231	40,212,508	0.214906	0.000000
65.00	06500	RESPIRATORY THERAPY	6,577,264	6,296,410	12,873,674	0.155683	0.000000
66.00	06600	PHYSICAL THERAPY	3,301,949	5,541,742	8,843,691	0.382590	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,165,166	2,729,522	4,894,688	0.381378	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,280,957	3,429,644	8,710,601	0.412356	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	8,707,720	6,554,520	15,262,240	0.311739	0.000000
76.00	03020	CARDIAC REHAB	23,846	909,922	933,768	1.030012	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	14,753	14,753	0.588965	0.000000
90.01	09001	WOUND CENTER	25,430	2,469,025	2,494,455	0.200826	0.000000
91.00	09100	EMERGENCY	4,464,878	20,915,855	25,380,733	0.170667	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	23,638	3,503,198	3,526,836	0.573220	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	11,422,307	11,422,307	0.414017	0.000000
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	85,010,967	185,524,657	270,535,624		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	85,010,967	185,524,657	270,535,624		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0275

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
9/24/2019 11:40 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.260879		50.00
53.00	05300	ANESTHESIOLOGY	0.027231		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205727		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.365357		55.00
57.00	05700	CT SCAN	0.026408		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.083589		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.128086		59.00
60.00	06000	LABORATORY	0.214906		60.00
65.00	06500	RESPIRATORY THERAPY	0.155683		65.00
66.00	06600	PHYSICAL THERAPY	0.382590		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.381378		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.412356		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.311739		73.00
76.00	03020	CARDIAC REHAB	1.030012		76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.588965		90.00
90.01	09001	WOUND CENTER	0.200826		90.01
91.00	09100	EMERGENCY	0.170667		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.573220		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.414017		95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0275

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
9/24/2019 11:40 am

				Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,145,163		11,145,163	0	11,145,163	30.00	
31.00	03100	INTENSIVE CARE UNIT	1,926,190		1,926,190	0	1,926,190	31.00	
43.00	04300	NURSERY	556,132		556,132	0	556,132	43.00	
44.00	04400	SKILLED NURSING FACILITY	6,522,064		6,522,064	0	6,522,064	44.00	
45.00	04500	NURSING FACILITY	729,982		729,982	0	729,982	45.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,282,237		5,282,237	0	5,282,237	50.00	
53.00	05300	ANESTHESIOLOGY	78,872		78,872	0	78,872	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,676,459		2,676,459	0	2,676,459	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	9,538,230		9,538,230	0	9,538,230	55.00	
57.00	05700	CT SCAN	753,115		753,115	0	753,115	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	486,005		486,005	0	486,005	58.00	
59.00	05900	CARDIAC CATHETERIZATION	1,520,464		1,520,464	0	1,520,464	59.00	
60.00	06000	LABORATORY	8,641,907		8,641,907	0	8,641,907	60.00	
65.00	06500	RESPIRATORY THERAPY	2,004,216	0	2,004,216	0	2,004,216	65.00	
66.00	06600	PHYSICAL THERAPY	3,383,507	0	3,383,507	0	3,383,507	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,866,725		1,866,725	0	1,866,725	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,591,872		3,591,872	0	3,591,872	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	4,757,830		4,757,830	0	4,757,830	73.00	
76.00	03020	CARDIAC REHAB	961,792		961,792	0	961,792	76.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	8,689		8,689	0	8,689	90.00	
90.01	09001	WOUND CENTER	500,952		500,952	0	500,952	90.01	
91.00	09100	EMERGENCY	4,331,641		4,331,641	0	4,331,641	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,021,652		2,021,652	0	2,021,652	92.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	4,729,028		4,729,028	0	4,729,028	95.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	78,014,724	0	78,014,724	0	78,014,724	200.00	
201.00		Less Observation Beds	2,021,652		2,021,652		2,021,652	201.00	
202.00		Total (see instructions)	75,993,072	0	75,993,072	0	75,993,072	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0275

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
9/24/2019 11:40 am

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	14,181,759		14,181,759		30.00
31.00	03100	INTENSIVE CARE UNIT	3,070,568		3,070,568		31.00
43.00	04300	NURSERY	1,094,969		1,094,969		43.00
44.00	04400	SKILLED NURSING FACILITY	8,095,089		8,095,089		44.00
45.00	04500	NURSING FACILITY	1,059,317		1,059,317		45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,095,643	14,152,193	20,247,836	0.260879	0.000000
53.00	05300	ANESTHESIOLOGY	951,477	1,944,904	2,896,381	0.027231	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,588,460	11,421,293	13,009,753	0.205727	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	215,241	25,891,380	26,106,621	0.365357	0.000000
57.00	05700	CT SCAN	5,056,612	23,461,621	28,518,233	0.026408	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	369,178	5,445,044	5,814,222	0.083589	0.000000
59.00	05900	CARDIAC CATHETERIZATION	4,064,529	7,806,093	11,870,622	0.128086	0.000000
60.00	06000	LABORATORY	8,597,277	31,615,231	40,212,508	0.214906	0.000000
65.00	06500	RESPIRATORY THERAPY	6,577,264	6,296,410	12,873,674	0.155683	0.000000
66.00	06600	PHYSICAL THERAPY	3,301,949	5,541,742	8,843,691	0.382590	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,165,166	2,729,522	4,894,688	0.381378	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,280,957	3,429,644	8,710,601	0.412356	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	8,707,720	6,554,520	15,262,240	0.311739	0.000000
76.00	03020	CARDIAC REHAB	23,846	909,922	933,768	1.030012	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	14,753	14,753	0.588965	0.000000
90.01	09001	WOUND CENTER	25,430	2,469,025	2,494,455	0.200826	0.000000
91.00	09100	EMERGENCY	4,464,878	20,915,855	25,380,733	0.170667	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	23,638	3,503,198	3,526,836	0.573220	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	11,422,307	11,422,307	0.414017	0.000000
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	85,010,967	185,524,657	270,535,624		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	85,010,967	185,524,657	270,535,624		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0275

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
9/24/2019 11:40 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
44.00	04400	SKILLED NURSING FACILITY				44.00
45.00	04500	NURSING FACILITY				45.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03020	CARDIAC REHAB	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
90.01	09001	WOUND CENTER	0.000000			90.01
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS				Provider CCN: 14-0275	Period: From 07/01/2018 To 06/30/2019	Worksheet D Part I Date/Time Prepared: 9/24/2019 11:40 am		
				Title XVIII	Hospital	PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	1,057,483	0	1,057,483	10,050	105.22	30.00	
31.00	INTENSIVE CARE UNIT	140,925		140,925	1,037	135.90	31.00	
43.00	NURSERY	34,985		34,985	798	43.84	43.00	
44.00	SKILLED NURSING FACILITY	405,698		405,698	25,174	16.12	44.00	
45.00	NURSING FACILITY	102,189		102,189	5,602	18.24	45.00	
200.00	Total (lines 30 through 199)	1,741,280		1,741,280	42,661		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	3,174	333,968					30.00
31.00	INTENSIVE CARE UNIT	394	53,545					31.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	3,164	51,004					44.00
45.00	NURSING FACILITY	0	0					45.00
200.00	Total (lines 30 through 199)	6,732	438,517					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0275

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part II
Date/Time Prepared:
9/24/2019 11:40 am

Cost Center Description			Title XVIII		Hospital	PPS	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	687,006	20,247,836	0.033930	2,272,845	77,118
53.00	05300	ANESTHESIOLOGY	13,501	2,896,381	0.004661	292,210	1,362
54.00	05400	RADIOLOGY-DIAGNOSTIC	351,384	13,009,753	0.027009	521,062	14,073
55.00	05500	RADIOLOGY-THERAPEUTIC	295,265	26,106,621	0.011310	64,913	734
57.00	05700	CT SCAN	98,486	28,518,233	0.003453	1,567,250	5,412
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	137,692	5,814,222	0.023682	130,615	3,093
59.00	05900	CARDIAC CATHETERIZATION	77,972	11,870,622	0.006568	1,914,126	12,572
60.00	06000	LABORATORY	614,871	40,212,508	0.015291	3,176,051	48,565
65.00	06500	RESPIRATORY THERAPY	202,611	12,873,674	0.015738	3,072,156	48,350
66.00	06600	PHYSICAL THERAPY	443,570	8,843,691	0.050157	557,760	27,976
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	129,177	4,894,688	0.026391	893,763	23,587
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	110,739	8,710,601	0.012713	2,750,682	34,969
73.00	07300	DRUGS CHARGED TO PATIENTS	131,012	15,262,240	0.008584	3,769,743	32,359
76.00	03020	CARDIAC REHAB	194,278	933,768	0.208058	12,528	2,607
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	152	14,753	0.010303	0	0
90.01	09001	WOUND CENTER	82,794	2,494,455	0.033191	16,319	542
91.00	09100	EMERGENCY	288,987	25,380,733	0.011386	2,254,967	25,675
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	191,820	3,526,836	0.054389	4,882	266
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					
200.00		Total (lines 50 through 199)	4,051,317	231,611,615		23,271,872	359,260

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0275		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part III Date/Time Prepared: 9/24/2019 11:40 am		
					Title XVIII		Hospital		PPS		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost				
			1A	1.00	2A	2.00	3.00				
	INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00		
43.00	04300	NURSERY	0	0	0	0	0	0	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	44.00		
45.00	04500	NURSING FACILITY	0	0	0	0	0	0	45.00		
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	10,050	0.00	3,174		30.00		
31.00	03100	INTENSIVE CARE UNIT		0	1,037	0.00	394		31.00		
43.00	04300	NURSERY		0	798	0.00	0		43.00		
44.00	04400	SKILLED NURSING FACILITY		0	25,174	0.00	3,164		44.00		
45.00	04500	NURSING FACILITY		0	5,602	0.00	0		45.00		
200.00		Total (lines 30 through 199)		0	42,661		6,732		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
44.00	04400	SKILLED NURSING FACILITY	0								44.00
45.00	04500	NURSING FACILITY	0								45.00
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0275

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

Worksheet D
Part IV
Date/Time Prepared:
9/24/2019 11:40 am

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOUND CENTER	0	0	0	0	90.01
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
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: 14-0275

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part IV
Date/Time Prepared:
9/24/2019 11:40 am

				Title XVIII		Hospital	PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	20,247,836	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,896,381	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,009,753	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	26,106,621	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	28,518,233	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	5,814,222	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	11,870,622	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	40,212,508	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	12,873,674	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,843,691	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,894,688	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	8,710,601	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	15,262,240	0.000000	73.00
76.00	03020	CARDIAC REHAB	0	0	0	933,768	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	14,753	0.000000	90.00
90.01	09001	WOUND CENTER	0	0	0	2,494,455	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	25,380,733	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,526,836	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	231,611,615		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0275

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part IV
Date/Time Prepared:
9/24/2019 11:40 am

Cost Center Description		Title XVIII			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	2,272,845	0	3,704,086	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	292,210	0	426,349	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	521,062	0	2,068,187	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	64,913	0	10,330,132	0	55.00
57.00	05700	CT SCAN	0.000000	1,567,250	0	5,746,401	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	130,615	0	1,065,973	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	1,914,126	0	3,560,468	0	59.00
60.00	06000	LABORATORY	0.000000	3,176,051	0	3,088,760	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	3,072,156	0	1,892,612	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	557,760	0	62,335	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	893,763	0	762,758	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	2,750,682	0	727,814	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	3,769,743	0	1,614,984	0	73.00
76.00	03020	CARDIAC REHAB	0.000000	12,528	0	413,758	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	133	0	90.00
90.01	09001	WOUND CENTER	0.000000	16,319	0	1,011,855	0	90.01
91.00	09100	EMERGENCY	0.000000	2,254,967	0	2,951,295	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	4,882	0	805,358	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		23,271,872	0	40,233,258	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0275		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part V Date/Time Prepared: 9/24/2019 11:40 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
					PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
				1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.260879	3,704,086	0	0	966,318	50.00
53.00	05300	ANESTHESIOLOGY		0.027231	426,349	0	0	11,610	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.205727	2,068,187	0	0	425,482	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0.365357	10,330,132	0	0	3,774,186	55.00
57.00	05700	CT SCAN		0.026408	5,746,401	0	0	151,751	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.083589	1,065,973	0	0	89,104	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.128086	3,560,468	0	0	456,046	59.00
60.00	06000	LABORATORY		0.214906	3,088,760	0	0	663,793	60.00
65.00	06500	RESPIRATORY THERAPY		0.155683	1,892,612	0	0	294,648	65.00
66.00	06600	PHYSICAL THERAPY		0.382590	62,335	0	0	23,849	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.381378	762,758	0	0	290,899	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT		0.412356	727,814	0	0	300,118	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.311739	1,614,984	0	14,692	503,453	73.00
76.00	03020	CARDIAC REHAB		1.030012	413,758	0	0	426,176	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.588965	133	0	0	78	90.00
90.01	09001	WOUND CENTER		0.200826	1,011,855	0	0	203,207	90.01
91.00	09100	EMERGENCY		0.170667	2,951,295	0	0	503,689	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.573220	805,358	0	0	461,647	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES		0.414017		0			95.00
200.00		Subtotal (see instructions)			40,233,258	0	14,692	9,546,054	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0		201.00
202.00		Net Charges (line 200 - line 201)			40,233,258	0	14,692	9,546,054	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0275		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part V Date/Time Prepared: 9/24/2019 11:40 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				Costs					
				Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
				6.00	7.00				
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0					
53.00	05300	ANESTHESIOLOGY	0	0					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0					
57.00	05700	CT SCAN	0	0					
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0					
59.00	05900	CARDIAC CATHETERIZATION	0	0					
60.00	06000	LABORATORY	0	0					
65.00	06500	RESPIRATORY THERAPY	0	0					
66.00	06600	PHYSICAL THERAPY	0	0					
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0					
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0					
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,580					
76.00	03020	CARDIAC REHAB	0	0					
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0					
90.01	09001	WOUND CENTER	0	0					
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						
200.00		Subtotal (see instructions)	0	4,580					
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						
202.00		Net Charges (line 200 - line 201)	0	4,580					

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0275 Component CCN: 14-5703		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 9/24/2019 11:40 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.01	09001	WOUND CENTER	0	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0275 Component CCN: 14-5703		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 9/24/2019 11:40 am	
			Title XVIII		Skilled Nursing Facility		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	20,247,836	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,896,381	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,009,753	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	26,106,621	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	28,518,233	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	5,814,222	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	11,870,622	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	40,212,508	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	12,873,674	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,843,691	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,894,688	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	8,710,601	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	15,262,240	0.000000	73.00
76.00	03020	CARDIAC REHAB	0	0	0	933,768	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	14,753	0.000000	90.00
90.01	09001	WOUND CENTER	0	0	0	2,494,455	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	25,380,733	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,526,836	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	231,611,615		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0275 Component CCN: 14-5703		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 9/24/2019 11:40 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	14,704	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	48,737	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	36,474	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	918,295	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	340	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	296,196	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0.000000	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00
90.01	09001	WOUND CENTER	0.000000	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	49,059	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)			1,363,805	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0275	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 9/24/2019 11:40 am
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		10,050	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		10,050	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)		8,227	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)		3,174	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)		11,145,163	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)		11,145,163	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)		11,145,163	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,108.97	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,519,871	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)		3,519,871	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0275

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

Worksheet D-1

Date/Time Prepared:
9/24/2019 11:40 am

Cost Center Description		Title XVIII			Hospital	PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,926,190	1,037	1,857.46	394	731,839	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description						
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					5,457,639	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					9,709,349	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)					387,513	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					359,260	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					746,773	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					8,962,576	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)					1,823	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,108.97	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,021,652	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0275

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

Worksheet D-1

Date/Time Prepared:
9/24/2019 11:40 am

Cost Center Description		Title XVIII		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,057,483	11,145,163	0.094883	2,021,652	191,820
91.00	Nursing School cost	0	11,145,163	0.000000	2,021,652	0
92.00	Allied health cost	0	11,145,163	0.000000	2,021,652	0
93.00	All other Medical Education	0	11,145,163	0.000000	2,021,652	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0275 Component CCN: 14-5703	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 9/24/2019 11:40 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		25,174	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		25,174	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)		25,174	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)		3,164	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)		6,522,064	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)		6,522,064	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)		6,522,064	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)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0275 Component CCN: 14-5703	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 9/24/2019 11:40 am
			Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					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)					48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					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)					50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					54.00
55.00 Target amount per discharge					55.00
56.00 Target amount (line 54 x line 55)					56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					57.00
58.00 Bonus payment (see instructions)					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					59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					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)					61.00
62.00 Relief payment (see instructions)					62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					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)					64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					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)					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)					68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					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)				6,522,064	70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				259.08	71.00
72.00 Program routine service cost (line 9 x line 71)				819,729	72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)				0	73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)				819,729	74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				0	75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)				0.00	76.00
77.00 Program capital-related costs (line 9 x line 76)				0	77.00
78.00 Inpatient routine service cost (line 74 minus line 77)				0	78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)				0	79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				0	80.00
81.00 Inpatient routine service cost per diem limitation				0.00	81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)				0	82.00
83.00 Reasonable inpatient routine service costs (see instructions)				819,729	83.00
84.00 Program inpatient ancillary services (see instructions)				471,346	84.00
85.00 Utilization review - physician compensation (see instructions)				0	85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)				1,291,075	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)				0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)				0	89.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0275 Component CCN: 14-5703		Period: From 07/01/2018 To 06/30/2019		Worksheet D-1 Date/Time Prepared: 9/24/2019 11:40 am
			Title XVIII		Skilled Nursing Facility		PPS
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0275	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 9/24/2019 11:40 am	
			Title XVIII	Hospital	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		3,974,738		30.00
31.00	03100	INTENSIVE CARE UNIT		1,095,623		31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.260879	2,272,845	592,938	50.00
53.00	05300	ANESTHESIOLOGY	0.027231	292,210	7,957	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205727	521,062	107,197	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.365357	64,913	23,716	55.00
57.00	05700	CT SCAN	0.026408	1,567,250	41,388	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.083589	130,615	10,918	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.128086	1,914,126	245,173	59.00
60.00	06000	LABORATORY	0.214906	3,176,051	682,552	60.00
65.00	06500	RESPIRATORY THERAPY	0.155683	3,072,156	478,282	65.00
66.00	06600	PHYSICAL THERAPY	0.382590	557,760	213,393	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.381378	893,763	340,862	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.412356	2,750,682	1,134,260	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.311739	3,769,743	1,175,176	73.00
76.00	03020	CARDIAC REHAB	1.030012	12,528	12,904	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.588965	0	0	90.00
90.01	09001	WOUND CENTER	0.200826	16,319	3,277	90.01
91.00	09100	EMERGENCY	0.170667	2,254,967	384,848	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.573220	4,882	2,798	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		23,271,872	5,457,639	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)		23,271,872		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0275 Component CCN: 14-5703	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 9/24/2019 11:40 am	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.260879	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.027231	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.205727	14,704	3,025	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.365357	0	0	55.00
57.00	05700 CT SCAN	0.026408	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.083589	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.128086	0	0	59.00
60.00	06000 LABORATORY	0.214906	48,737	10,474	60.00
65.00	06500 RESPIRATORY THERAPY	0.155683	36,474	5,678	65.00
66.00	06600 PHYSICAL THERAPY	0.382590	918,295	351,330	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.381378	340	130	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.412356	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.311739	296,196	92,336	73.00
76.00	03020 CARDIAC REHAB	1.030012	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.588965	0	0	90.00
90.01	09001 WOUND CENTER	0.200826	0	0	90.01
91.00	09100 EMERGENCY	0.170667	49,059	8,373	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.573220	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,363,805	471,346	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)		1,363,805		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0275	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prepared: 9/24/2019 11:40 am
		Title XVIII	Hospital	PPS
				1.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		2,280,026	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		6,840,078	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)		45,157	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)		140.01	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)		4.83	30.00
31.00	Percentage of Medicaid patient days (see instructions)		23.84	31.00
32.00	Sum of lines 30 and 31		28.67	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.87	33.00
34.00	Disproportionate share adjustment (see instructions)		293,440	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0275	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prepared: 9/24/2019 11:40 am	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	629,367	676,630		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	158,635	506,082		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	664,717			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)	10,123,418			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)		10,123,418		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		787,605		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)		10,911,023		59.00
60.00	Primary payer payments		35,061		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		10,875,962		61.00
62.00	Deductibles billed to program beneficiaries		1,223,596		62.00
63.00	Coinsurance billed to program beneficiaries		5,025		63.00
64.00	Allowable bad debts (see instructions)		184,471		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		119,906		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		153,804		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		9,767,247		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0		70.50
70.87	Demonstration payment adjustment amount before sequestration		0		70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0		70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)				70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		33,830		70.93
70.94	HRR adjustment amount (see instructions)		-38,025		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0275	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prepared: 9/24/2019 11:40 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)		Amount	
		0		1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0		0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			27,372	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			9,735,680	71.00
71.01	Sequestration adjustment (see instructions)			194,714	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
72.00	Interim payments			9,373,070	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)			167,896	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0275	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 9/24/2019 11:40 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			4,580 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			9,546,054 2.00
3.00	OPPS payments			9,229,228 3.00
4.00	Outlier payment (see instructions)			11,215 4.00
4.01	Outlier reconciliation amount (see instructions)			0 4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.274 5.00
6.00	Line 2 times line 5			2,615,619 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)			4,580 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			14,692 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)			14,692 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)			14,692 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			10,112 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)			4,580 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			9,240,443 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)			1,758,223 26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			7,486,800 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			7,486,800 30.00
31.00	Primary payer payments			3,875 31.00
32.00	Subtotal (line 30 minus line 31)			7,482,925 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)			192,230 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			124,950 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			148,386 36.00
37.00	Subtotal (see instructions)			7,607,875 37.00
38.00	MSP-LCC reconciliation amount from PS&R			-299 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)			7,608,174 40.00
40.01	Sequestration adjustment (see instructions)			152,163 40.01
40.02	Demonstration payment adjustment amount after sequestration			0 40.02
41.00	Interim payments			7,447,287 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			8,724 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: 14-0275

Period:
From 07/01/2018
To 06/30/2019Worksheet E-1
Part I
Date/Time Prepared:
9/24/2019 11:40 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		9,373,070		7,447,287	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)		9,373,070		7,447,287	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		167,896		8,724	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		9,540,966		7,456,011	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: 14-0275

Period:

Worksheet E-1

Component CCN: 14-5703

From 07/01/2018

Part I

To 06/30/2019

Date/Time Prepared:

9/24/2019 11:40 am

Title XVIII

Skilled Nursing
Facility

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	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		1,303,971		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)		1,303,971		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)		1,303,971		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: 14-0275

Period:
From 07/01/2018
To 06/30/2019Worksheet E-1
Part II
Date/Time Prepared:
9/24/2019 11:40 am

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0275 Component CCN: 14-5703	Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part VI Date/Time Prepared: 9/24/2019 11:40 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES			
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)			
1.00	Resource Utilization Group Payment (RUGS)		1,470,113	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		1,470,113	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES			
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		137,210	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		1,332,903	12.00
13.00	Inpatient primary payer payments		2,320	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Demonstration payment adjustment amount before sequestration		0	14.99
15.00	Subtotal (see instructions)		1,330,583	15.00
15.01	Sequestration adjustment (see instructions)		26,612	15.01
15.02	Demonstration payment adjustment amount after sequestration		0	15.02
16.00	Interim payments		1,303,971	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)		0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

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

Provider CCN: 14-0275

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

Worksheet G

Date/Time Prepared:
9/24/2019 11:40 am

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	15,492,560	0	0	0	1.00
2.00 Temporary investments	664,990	0	0	0	2.00
3.00 Notes receivable	1,878,510	0	0	0	3.00
4.00 Accounts receivable	43,717,102	0	0	0	4.00
5.00 Other receivable	589,377	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-26,443,868	0	0	0	6.00
7.00 Inventory	3,038,664	0	0	0	7.00
8.00 Prepaid expenses	487,439	0	0	0	8.00
9.00 Other current assets	0	0	0	0	9.00
10.00 Due from other funds	25,922,556	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	65,347,330	0	0	0	11.00
FIXED ASSETS					
12.00 Land	2,328,680	0	0	0	12.00
13.00 Land improvements	5,145,646	0	0	0	13.00
14.00 Accumulated depreciation	-2,371,265	0	0	0	14.00
15.00 Buildings	61,128,158	0	0	0	15.00
16.00 Accumulated depreciation	-38,673,422	0	0	0	16.00
17.00 Leasehold improvements	2,090,594	0	0	0	17.00
18.00 Accumulated depreciation	-636,582	0	0	0	18.00
19.00 Fixed equipment	0	0	0	0	19.00
20.00 Accumulated depreciation	0	0	0	0	20.00
21.00 Automobiles and trucks	0	0	0	0	21.00
22.00 Accumulated depreciation	0	0	0	0	22.00
23.00 Major movable equipment	51,404,208	0	0	0	23.00
24.00 Accumulated depreciation	-44,420,083	0	0	0	24.00
25.00 Minor equipment depreciable	0	0	0	0	25.00
26.00 Accumulated depreciation	0	0	0	0	26.00
27.00 HIT designated Assets	0	0	0	0	27.00
28.00 Accumulated depreciation	0	0	0	0	28.00
29.00 Minor equipment-nondepreciable	0	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	35,995,934	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	10,961,214	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	287,747	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	11,248,961	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	112,592,225	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	1,799,070	0	0	0	37.00
38.00 Salaries, wages, and fees payable	1,532,179	0	0	0	38.00
39.00 Payroll taxes payable	288,961	0	0	0	39.00
40.00 Notes and loans payable (short term)	1,813,024	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	4,235,928	0	0	0	43.00
44.00 Other current liabilities	5,526,151	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	15,195,313	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	1,723,327	0	0	0	46.00
47.00 Notes payable	0	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	0	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	1,723,327	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	16,918,640	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	95,673,585				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)	95,673,585	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	112,592,225	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0275

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

Worksheet G-1

Date/Time Prepared:
9/24/2019 11:40 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		96,106,239		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,493,463				2.00
3.00	Total (sum of line 1 and line 2)		101,599,702		0		3.00
4.00	ADDITIONS	0		0		0	4.00
5.00	ROUNDING	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)		101,599,702		0		11.00
12.00	DEDUCTIONS	437,195		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)		437,195		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		101,162,507		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		0				4.00
5.00	ROUNDING		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		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: 14-0275

Period:
From 07/01/2018
To 06/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
9/24/2019 11:40 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	10,902,721		10,902,721	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	7,228,404		7,228,404	7.00
8.00	NURSING FACILITY	1,056,785		1,056,785	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	19,187,910		19,187,910	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	2,823,630		2,823,630	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)	2,823,630		2,823,630	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	22,011,540		22,011,540	17.00
18.00	Ancillary services	63,923,493	187,975,689	251,899,182	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	11,486,199	11,486,199	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	CROSSTOWN SQUARE	1,244,161	0	1,244,161	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	87,179,194	199,461,888	286,641,082	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		94,721,814		29.00
30.00	INCOME TAX	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	INCOME TAX	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)		94,721,814		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0275

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

Worksheet G-3

Date/Time Prepared:
9/24/2019 11:40 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	286,641,082	1.00
2.00	Less contractual allowances and discounts on patients' accounts	182,050,380	2.00
3.00	Net patient revenues (line 1 minus line 2)	104,590,702	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	94,721,814	4.00
5.00	Net income from service to patients (line 3 minus line 4)	9,868,888	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 OPERATING REVENUE	3,991,719	24.00
24.01	BAD DEBTS	-3,682,361	24.01
24.02	CHARITY CARE	-4,358,259	24.02
24.03	NONOPERATING GAINS & LOSSES	-286,678	24.03
24.04	ROUNDING	0	24.04
24.05	ROUNDING	-2	24.05
25.00	Total other income (sum of lines 6-24)	-4,335,581	25.00
26.00	Total (line 5 plus line 25)	5,533,307	26.00
27.00	COGS	39,844	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	39,844	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,493,463	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0275	Period: From 07/01/2018 To 06/30/2019	Worksheet L Parts I-III Date/Time Prepared: 9/24/2019 11:40 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		739,431	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		3,956	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)		25.65	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)		4.83	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		23.84	8.00
9.00	Sum of lines 7 and 8		28.67	9.00
10.00	Allowable disproportionate share percentage (see instructions)		5.98	10.00
11.00	Disproportionate share adjustment (see instructions)		44,218	11.00
12.00	Total prospective capital payments (see instructions)		787,605	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