

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: 14-1334	Period: From 04/01/2018 To 03/31/2019	Worksheet S Parts I-III Date/Time Prepared: 8/14/2019 12:02 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 8/14/2019	Time: 12:02 pm
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SAINT JOSEPH MEMORIAL HOSPITAL (14-1334) for the cost reporting period beginning 04/01/2018 and ending 03/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) _____

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	11,385	10,118	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	-63,568	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-52,183	10,118	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: 14-1334		Period: From 04/01/2018 To 03/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/14/2019 12:00 pm				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 2 SOUTH HOSPITAL DRIVE			PO Box:				1.00				
2.00	City: MURPHYSBORO			State: IL		Zip Code: 62966		County:				
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
								V	XVIII			
								XIX				
1.00		2.00		3.00	4.00	5.00	6.00	7.00	8.00			
Hospital and Hospital-Based Component Identification:												
3.00	Hospital			SAINT JOSEPH MEMORIAL HOSPITAL	141334	16060	1	05/01/2004	N	0	0	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			ST JOSEPH HOSPITAL SWING BED	14Z334	16060		11/14/2013	N	0	0	7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
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)						04/01/2018	03/31/2019		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.					N	N			22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					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.			0	0	0	0	0	0	24.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet S-2
Part I
Date/Time Prepared:
8/14/2019 12:00 pm

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
	1.00	2.00	3.00	4.00	5.00	6.00		
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00	
					Urban/Rural S	Date of Geogr		
					1.00	2.00		
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2						26.00	
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2 09/15/2014						27.00	
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0						35.00	
					Beginning:	Ending:		
					1.00	2.00		
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0						37.00	
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01	
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
					Y/N	Y/N		
					1.00	2.00		
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N					N	39.00	
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N					N	40.00	
					V	XVIII	XIX	
					1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital								
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N					N	N	45.00
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N					N	N	46.00
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.	N					N	N	47.00
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N					N	N	48.00
Teaching Hospitals								
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N							56.00
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N							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: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet S-2
Part I
Date/Time Prepared:
8/14/2019 12:00 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet S-2
Part I
Date/Time Prepared:
8/14/2019 12:00 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1334	Period: From 04/01/2018 To 03/31/2019	Worksheet S-2 Part I Date/Time Prepared: 8/14/2019 12:00 pm	
				1.00	
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	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?		Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.		N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
			Physical	Occupational	
			1.00	2.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N	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: 14-1334	Period: From 04/01/2018 To 03/31/2019	Worksheet S-2 Part I Date/Time Prepared: 8/14/2019 12:00 pm	
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
			1.00	2.00	3.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	507,032	0	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	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		14H124	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1334		Period: From 04/01/2018 To 03/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/14/2019 12:00 pm		
1.00		2.00		3.00						
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.										
141.00	Name: SOUTHERN ILLINOIS HEALTHCARE	Contractor's Name: NGS		Contractor's Number: 06101						
142.00	Street: 1239 E MAIN	PO Box: 3988								
143.00	City: CARBONDALE	State: IL		Zip Code: 62902-3988						
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?								Y	144.00
								1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.						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	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital	N	N	N	N	N	155.00			
156.00	Subprovider - IPF	N	N	N	N	N	156.00			
157.00	Subprovider - IRF	N	N	N	N	N	157.00			
158.00	SUBPROVIDER						158.00			
159.00	SNF	N	N	N	N	N	159.00			
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00			
161.00	CMHC		N	N	N	N	161.00			
								1.00		
Multicampus										
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus			
		0	1.00	2.00	3.00	4.00	5.00			
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00			
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								N	168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								0.00	169.00
						Beginning	Ending			
						1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					10/01/2018	12/31/2018		170.00	
						1.00	2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N	0		171.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1334	Period: From 04/01/2018 To 03/31/2019	Worksheet S-2 Part II Date/Time Prepared: 8/14/2019 12:00 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	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)	Y	08/05/2019	Y 08/05/2019
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet S-2
Part II
Date/Time Prepared:
8/14/2019 12:00 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		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		Y		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.		Y		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.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LUANNE	WARREN		41.00
42.00	Enter the employer/company name of the cost report preparer.	SIH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	618-457-5200	LUANNE.WARREN@SIH.NET		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet S-2
Part II
Date/Time Prepared:
8/14/2019 12:00 pm

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

HFS Supplemental Information

Provider CCN: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet S-2
Part IX
Date/Time Prepared:
8/14/2019 12:00 pm

		Title V	Title XIX	
		1.00	2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.01)	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.02)	Y	Y	3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?	N	N	3.01
		Inpatient	Outpatient	
		1.00	2.00	
CRITICAL ACCESS HOSPITALS				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
RCE DISALLOWANCE				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.05)	Y	Y	6.00
PASS THROUGH COST				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.06)	Y	Y	7.00
RHC				
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	8.00
FQHC				
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	9.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/14/2019 12:00 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	24,140.22	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)		25	9,125	24,140.22	0	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)		25	9,125	24,140.22	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25			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: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/14/2019 12:00 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	575	32	983			1.00
2.00	HMO and other (see instructions)	72	73				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	1,812	0	3,257			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	310			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,387	32	4,550			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)	2,387	32	4,550	0.00	229.26	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	229.26	27.00
28.00	Observation Bed Days		13	348			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/14/2019 12:00 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	211	10	353	1.00
2.00 HMO and other (see instructions)			27	32		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	211	10	353	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1334

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

Worksheet S-10

Date/Time Prepared:
8/14/2019 12:00 pm

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.220339	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		6,022,720	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		3,043,653	5.00
6.00	Medicaid charges		45,335,901	6.00
7.00	Medicaid cost (line 1 times line 6)		9,989,267	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)		922,894	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		22,360	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		922,894	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	879,446	266,196	1,145,642
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	193,776	266,196	459,972
22.00	Payments received from patients for amounts previously written off as charity care	1,437	6,336	7,773
23.00	Cost of charity care (line 21 minus line 22)	192,339	259,860	452,199
			1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		6,053,035	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		1,474,959	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		2,269,168	27.01
28.00	Non-Medicare bad debt expense (see instructions)		3,783,867	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,627,942	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		2,080,141	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,003,035	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1334

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

Worksheet A

Date/Time Prepared:
8/14/2019 12:00 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,464,105	1,464,105	100,197	1,564,302	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,619,951	1,619,951	53,953	1,673,904	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	90,270	5,301,224	5,391,494	0	5,391,494	4.00
5.01	00550	DATA PROCESSING	0	0	0	0	0	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	33,056	47,279	80,335	0	80,335	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	580,850	19,433	600,283	0	600,283	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	1,085,254	2,751,934	3,837,188	0	3,837,188	5.04
6.00	00600	MAINTENANCE & REPAIRS	303,683	637,762	941,445	0	941,445	6.00
7.00	00700	OPERATION OF PLANT	159,444	16,895	176,339	0	176,339	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	249,966	249,966	0	249,966	8.00
9.00	00900	HOUSEKEEPING	295,055	89,131	384,186	-172	384,014	9.00
10.00	01000	DIETARY	323,048	130,963	454,011	-281,778	172,233	10.00
11.00	01100	CAFETERIA	0	0	0	280,781	280,781	11.00
13.00	01300	NURSING ADMINISTRATION	1,099,557	128,528	1,228,085	0	1,228,085	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	35,207	254	35,461	0	35,461	14.00
15.00	01500	PHARMACY	524,344	8,254,299	8,778,643	-15,737	8,762,906	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	24,700	1,307	26,007	0	26,007	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	825,158	825,158	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,819,812	1,523,497	3,343,309	-24,796	3,318,513	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,493,812	3,311,004	4,804,816	-2,061,263	2,743,553	50.00
51.00	05100	RECOVERY ROOM	160,758	4,496	165,254	-775	164,479	51.00
53.00	05300	ANESTHESIOLOGY	265,384	865,230	1,130,614	-829,550	301,064	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,011,763	455,519	1,467,282	-50,064	1,417,218	54.00
60.00	06000	LABORATORY	676,398	1,415,018	2,091,416	-41	2,091,375	60.00
64.00	06400	INTRAVENOUS THERAPY	836,394	300,424	1,136,818	-15,585	1,121,233	64.00
65.00	06500	RESPIRATORY THERAPY	339,761	250,836	590,597	-44,383	546,214	65.00
65.01	03610	SLEEP LAB	615,892	213,665	829,557	0	829,557	65.01
65.02	03620	GERIATRIC PSYCH	0	412,173	412,173	0	412,173	65.02
66.00	06600	PHYSICAL THERAPY	781,249	302,339	1,083,588	-801	1,082,787	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	931,810	931,810	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,167,061	1,167,061	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	165,364	165,364	73.00
76.97	07697	CARDIAC REHABILITATION	325,836	22,695	348,531	520	349,051	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	188,027	375,482	563,509	-22,433	541,076	90.00
91.00	09100	EMERGENCY	1,096,335	3,216,130	4,312,465	-23,316	4,289,149	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		531,416	531,416	-154,150	377,266	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,165,889	33,912,955	48,078,844	0	48,078,844	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	25,316	25,316	0	25,316	192.00
192.01	19201	UNUSED SPACE	0	0	0	0	0	192.01
200.00		TOTAL (SUM OF LINES 118 through 199)	14,165,889	33,938,271	48,104,160	0	48,104,160	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1334

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

Worksheet A

Date/Time Prepared:
8/14/2019 12:00 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	54,371	1,618,673	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,425,994	3,099,898	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,767,989	3,623,505	4.00
5.01	00550	DATA PROCESSING	2,580,719	2,580,719	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	-2,133	78,202	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	739,685	1,339,968	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	39,590	3,876,778	5.04
6.00	00600	MAINTENANCE & REPAIRS	-15,426	926,019	6.00
7.00	00700	OPERATION OF PLANT	0	176,339	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	249,966	8.00
9.00	00900	HOUSEKEEPING	0	384,014	9.00
10.00	01000	DIETARY	-11	172,222	10.00
11.00	01100	CAFETERIA	-98,752	182,029	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,228,085	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	35,461	14.00
15.00	01500	PHARMACY	0	8,762,906	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-12,471	13,536	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-825,158	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,041,569	2,276,944	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	2,743,553	50.00
51.00	05100	RECOVERY ROOM	0	164,479	51.00
53.00	05300	ANESTHESIOLOGY	0	301,064	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-37,242	1,379,976	54.00
60.00	06000	LABORATORY	-18,317	2,073,058	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,121,233	64.00
65.00	06500	RESPIRATORY THERAPY	0	546,214	65.00
65.01	03610	SLEEP LAB	-7,545	822,012	65.01
65.02	03620	GERIATRIC PSYCH	0	412,173	65.02
66.00	06600	PHYSICAL THERAPY	0	1,082,787	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	931,810	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,167,061	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	165,364	73.00
76.97	07697	CARDIAC REHABILITATION	0	349,051	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-35,051	506,025	90.00
91.00	09100	EMERGENCY	-2,854,569	1,434,580	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-377,266	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,253,140	45,825,704	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-7,445	17,871	192.00
192.01	19201	UNUSED SPACE	0	0	192.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,260,585	45,843,575	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet Non-CMS W
Date/Time Prepared:
8/14/2019 12:00 pm

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.01	DATA PROCESSING	00550	DATA PROCESSING	5.01
5.02	PURCHASING RECEIVING AND STORES	00560	PURCHASING RECEIVING AND STORES	5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	00590		5.04
6.00	MAINTENANCE & REPAIRS	00600		6.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
19.00	NONPHYSICIAN ANESTHETISTS	01900		19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
60.00	LABORATORY	06000		60.00
64.00	INTRAVENOUS THERAPY	06400		64.00
65.00	RESPIRATORY THERAPY	06500		65.00
65.01	SLEEP LAB	03610	SLEEP LAB	65.01
65.02	GERIATRIC PSYCH	03620	STRESS TEST	65.02
66.00	PHYSICAL THERAPY	06600		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
76.97	CARDIAC REHABILITATION	07697		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
192.01	UNUSED SPACE	19201		192.01
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

RECLASSIFICATIONS

Provider CCN: 14-1334

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

Worksheet A-6

Date/Time Prepared:
8/14/2019 12:00 pm

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - DIETARY RECLASS					
1.00	CAFETERIA	11.00	200,227	81,172	1.00
	0		200,227	81,172	
B - MEDICAL SUPPLY RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,098,871	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
	0		0	2,098,871	
C - IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	91,866	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
	0		0	91,866	
D - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	100,197	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	53,953	2.00
	0		0	154,150	
E - CONTRAST RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	73,498	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	73,498	
F - CRNA RECLASS					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	825,158	1.00
	0		0	825,158	
G - IMPLANTABLE SUPPLY RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,167,061	1.00
	0		0	1,167,061	
H - CVP REHAB MED DIRECTOR RECLASS					
1.00	CARDIAC REHABILITATION	76.97	0	520	1.00
	TOTALS		0	520	
500.00	Grand Total: Increases		200,227	4,492,296	500.00

RECLASSIFICATIONS

Provider CCN: 14-1334

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

Worksheet A-6

Date/Time Prepared:
8/14/2019 12:00 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DIETARY RECLASS						
1.00	DIETARY	10.00	200,227	81,172	0		1.00
	0		200,227	81,172			
	B - MEDICAL SUPPLY RECLASS						
1.00	OPERATING ROOM	50.00	0	2,021,369	0		1.00
2.00	ANESTHESIOLOGY	53.00	0	164	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	34,631	0		3.00
4.00	INTRAVENOUS THERAPY	64.00	0	6,605	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	1,717	0		5.00
6.00	CLINIC	90.00	0	22,428	0		6.00
7.00	LABORATORY	60.00	0	41	0		7.00
8.00	HOUSEKEEPING	9.00	0	172	0		8.00
9.00	EMERGENCY	91.00	0	9,045	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,898	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	801	0		11.00
	0		0	2,098,871			
	C - IV SOLUTIONS						
1.00	DIETARY	10.00	0	379	0		1.00
2.00	CAFETERIA	11.00	0	618	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	23,079	0		3.00
4.00	OPERATING ROOM	50.00	0	22,709	0		4.00
5.00	RECOVERY ROOM	51.00	0	775	0		5.00
6.00	ANESTHESIOLOGY	53.00	0	4,228	0		6.00
7.00	EMERGENCY	91.00	0	14,271	0		7.00
8.00	INTRAVENOUS THERAPY	64.00	0	8,980	0		8.00
9.00	PHARMACY	15.00	0	15,737	0		9.00
10.00	CLINIC	90.00	0	5	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,085	0		11.00
	0		0	91,866			
	D - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	154,150	9		1.00
2.00		0.00	0	0	9		2.00
	0		0	154,150			
	E - CONTRAST RECLASS						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	47,081	0		1.00
2.00	OPERATING ROOM	50.00	0	17,185	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	9,232	0		3.00
	0		0	73,498			
	F - CRNA RECLASS						
1.00	ANESTHESIOLOGY	53.00	0	825,158	0		1.00
	0		0	825,158			
	G - IMPLANTABLE SUPPLY RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,167,061	0		1.00
	0		0	1,167,061			
	H - CVP REHAB MED DIRECTOR RECLASS						
1.00	RESPIRATORY THERAPY	65.00	0	520	0		1.00
	TOTALS		0	520			
500.00	Grand Total: Decreases		200,227	4,492,296			500.00

RECLASSIFICATIONS

Provider CCN: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
8/14/2019 12:00 pm

Increases					Decreases				
Cost Center	Line #	Salary	Other		Cost Center	Line #	Salary	Other	
2.00	3.00	4.00	5.00		6.00	7.00	8.00	9.00	
A - DIETARY RECLASS									
1.00	CAFETERIA	11.00	200,227	81,172	DIETARY	10.00	200,227	81,172	1.00
	0		200,227	81,172	0		200,227	81,172	
B - MEDICAL SUPPLY RECLASS									
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,098,871	OPERATING ROOM	50.00	0	2,021,369	1.00
2.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	164	2.00
3.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	34,631	3.00
4.00		0.00	0	0	INTRAVENOUS THERAPY	64.00	0	6,605	4.00
5.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	1,717	5.00
6.00		0.00	0	0	CLINIC	90.00	0	22,428	6.00
7.00		0.00	0	0	LABORATORY	60.00	0	41	7.00
8.00		0.00	0	0	HOUSEKEEPING	9.00	0	172	8.00
9.00		0.00	0	0	EMERGENCY	91.00	0	9,045	9.00
10.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	1,898	10.00
11.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	801	11.00
	0		0	2,098,871	0		0	2,098,871	
C - IV SOLUTIONS									
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	91,866	DIETARY	10.00	0	379	1.00
2.00		0.00	0	0	CAFETERIA	11.00	0	618	2.00
3.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	23,079	3.00
4.00		0.00	0	0	OPERATING ROOM	50.00	0	22,709	4.00
5.00		0.00	0	0	RECOVERY ROOM	51.00	0	775	5.00
6.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	4,228	6.00
7.00		0.00	0	0	EMERGENCY	91.00	0	14,271	7.00
8.00		0.00	0	0	INTRAVENOUS THERAPY	64.00	0	8,980	8.00
9.00		0.00	0	0	PHARMACY	15.00	0	15,737	9.00
10.00		0.00	0	0	CLINIC	90.00	0	5	10.00
11.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	1,085	11.00
	0		0	91,866	0		0	91,866	
D - INTEREST RECLASS									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	100,197	INTEREST EXPENSE	113.00	0	154,150	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	53,953		0.00	0	0	2.00
	0		0	154,150	0		0	154,150	
E - CONTRAST RECLASS									
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	73,498	RADIOLOGY-DIAGNOSTIC	54.00	0	47,081	1.00
2.00		0.00	0	0	OPERATING ROOM	50.00	0	17,185	2.00
3.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	9,232	3.00
	0		0	73,498	0		0	73,498	
F - CRNA RECLASS									
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	825,158	ANESTHESIOLOGY	53.00	0	825,158	1.00
	0		0	825,158	0		0	825,158	
G - IMPLANTABLE SUPPLY RECLASS									
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,167,061	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,167,061	1.00
	0		0	1,167,061	0		0	1,167,061	
H - CVP REHAB MED DIRECTOR RECLASS									
1.00	CARDIAC REHABILITATION	76.97	0	520	RESPIRATORY THERAPY	65.00	0	520	1.00
	TOTALS		0	520	TOTALS		0	520	
500.00	Grand Total: Increases		200,227	4,492,296	Grand Total: Decreases		200,227	4,492,296	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet A-7
Part I
Date/Time Prepared:
8/14/2019 12:00 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	171,136	0	0	0	0	1.00
2.00	Land Improvements	1,145,551	4,229	0	4,229	15,864	2.00
3.00	Buildings and Fixtures	28,286,261	2,750,467	0	2,750,467	2,034,780	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	16,285,260	1,373,706	0	1,373,706	1,189,242	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	45,888,208	4,128,402	0	4,128,402	3,239,886	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	45,888,208	4,128,402	0	4,128,402	3,239,886	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	171,136	0				1.00
2.00	Land Improvements	1,133,916	0				2.00
3.00	Buildings and Fixtures	29,001,948	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	16,469,724	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	46,776,724	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	46,776,724	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet A-7
Part II
Date/Time Prepared:
8/14/2019 12:00 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,464,105	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,619,951	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,084,056	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,464,105				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,619,951				2.00
3.00	Total (sum of lines 1-2)	0	3,084,056				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet A-7
Part III
Date/Time Prepared:
8/14/2019 12:00 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	30,307,001	0	30,307,001	0.647908	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	16,469,724	0	16,469,724	0.352092	0	2.00
3.00	Total (sum of lines 1-2)	46,776,725	0	46,776,725	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,618,673	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,099,898	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,718,571	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,618,673	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	3,099,898	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	4,718,571	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1334

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

Worksheet A-8

Date/Time Prepared:
8/14/2019 12:00 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		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	-3,940,154			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	8,805,997			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-98,752	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0	0MEDICAL RECORDS & LIBRARY	16.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-12,471	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-825,158	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1334

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

Worksheet A-8

Date/Time Prepared:
8/14/2019 12:00 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.00	PURCHASE DISCOUNTS	B	-2,133	PURCHASING RECEIVING AND STORES	5.02	0	33.00
33.01	EMPLOYEE OUTPATIENT INSURANCE PYMT	B	-3,114,839	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	LOBBYING EXPENSES	A	-13,093	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.02
33.03	UNRESTRICTED INTEREST REVENUE	B	-750,919	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.03
33.04	LEASEHOLD REVENUE	B	-34,830	CAP REL COSTS-BLDG & FIXT	1.00	9	33.04
33.05	XRAY FILM REVENUE	B	-1,115	RADIOLOGY-DIAGNOSTIC	54.00	0	33.05
33.06	NONALLOWABLE INTEREST EXPENSE	A	-377,266	INTEREST EXPENSE	113.00	0	33.06
33.07	REAL ESTATE TAXES	A	-5,030	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.07
33.08	MEDICAID PROVIDER TAX	A	-1,855,883	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.08
33.09	CABLE TV	A	-1,894	SLEEP LAB	65.01	0	33.09
33.10	CABLE TV	A	-15,426	MAINTENANCE & REPAIRS	6.00	0	33.10
33.11	SHAWNEE PARK DEPRECIATION	A	-8,881	CAP REL COSTS-BLDG & FIXT	1.00	9	33.11
33.12	REAL ESTATE TAXES	A	-5,651	SLEEP LAB	65.01	0	33.12
33.13	SHAWNEE PARK PROPERTY INSURANCE	A	-661	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.13
33.14	SHAWNEE PARK PROPERTY TAXES	A	-2,415	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.14
33.15	ALCOHOL PURCHASE	A	-11	DIETARY	10.00	0	33.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,260,585				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: 14-1334

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

Worksheet A-8-1

Date/Time Prepared:
8/14/2019 12:00 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	98,082	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	1,425,994	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	1,346,850	0	3.00
4.00	5.01	DATA PROCESSING	HOME OFFICE	2,580,719	0	4.00
4.01	5.03	CASHIERING/ACCOUNTS RECEIVAB	HOME OFFICE	739,685	0	4.01
4.02	5.04	OTHER ADMINISTRATIVE AND GEN	HOME OFFICE	2,669,111	0	4.02
4.03	54.00	RADIOLOGY-DIAGNOSTIC	RENT	43,877	80,004	4.03
4.04	60.00	LABORATORY	RENT	22,243	40,560	4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			8,926,561	120,564	5.00

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

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

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

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

6.00	B	SIHS	100.00	HOME OFFICE	100.00	6.00
7.00	B	SIHE	100.00	RELATED ORG	100.00	7.00
8.00	B	HSSI	100.00	RELATED ORG	100.00	8.00
9.00	B	SIMS	100.00	RELATED ORG	100.00	9.00
10.00	B	SIH CAYMAN	100.00	RELATED ORG	100.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-1334

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

Worksheet A-8-1

Date/Time Prepared:
8/14/2019 12:00 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	98,082	9		1.00
2.00	1,425,994	9		2.00
3.00	1,346,850	0		3.00
4.00	2,580,719	0		4.00
4.01	739,685	0		4.01
4.02	2,669,111	0		4.02
4.03	-36,127	0		4.03
4.04	-18,317	0		4.04
5.00	8,805,997			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	HEALTHCARE		6.00
7.00	HEALTHCARE		7.00
8.00	HEALTHCARE		8.00
9.00	HEALTHCARE		9.00
10.00	CAPTIVE		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: 14-1334

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

Worksheet A-8-2

Date/Time Prepared:
8/14/2019 12:00 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	DR. A	2,854,569	2,854,569	0	0	0	1.00
2.00	60.00	DR. B	175,046	0	175,046	0	0	2.00
3.00	76.97	DR. C	3,124	0	3,124	0	0	3.00
4.00	65.01	DR. D	13,704	0	13,704	0	0	4.00
5.00	5.04	DR. E	8,965	8,965	0	0	0	5.00
6.00	30.00	DR. F	1,041,569	1,041,569	0	0	0	6.00
7.00	90.00	DR. G	35,051	35,051	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			4,132,028	3,940,154	191,874		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	DR. A	0	0	0	0	0	1.00
2.00	60.00	DR. B	0	0	0	0	0	2.00
3.00	76.97	DR. C	0	0	0	0	0	3.00
4.00	65.01	DR. D	0	0	0	0	0	4.00
5.00	5.04	DR. E	0	0	0	0	0	5.00
6.00	30.00	DR. F	0	0	0	0	0	6.00
7.00	90.00	DR. G	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	DR. A	0	0	0	2,854,569		1.00
2.00	60.00	DR. B	0	0	0	0		2.00
3.00	76.97	DR. C	0	0	0	0		3.00
4.00	65.01	DR. D	0	0	0	0		4.00
5.00	5.04	DR. E	0	0	0	8,965		5.00
6.00	30.00	DR. F	0	0	0	1,041,569		6.00
7.00	90.00	DR. G	0	0	0	35,051		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	3,940,154		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet B
Part I
Date/Time Prepared:
8/14/2019 12:00 pm

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,618,673	1,618,673				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,099,898		3,099,898			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,623,505	15,125	28,965	3,667,595		4.00
5.01	00550	DATA PROCESSING	2,580,719	7,213	13,813	0	2,601,745	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	78,202	7,129	13,653	8,613	7,308	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,339,968	21,405	40,992	151,349	116,932	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	3,876,778	321,320	615,356	282,778	270,406	5.04
6.00	00600	MAINTENANCE & REPAIRS	926,019	142,170	272,268	79,129	116,932	6.00
7.00	00700	OPERATION OF PLANT	176,339	22,904	43,863	41,545	21,925	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	249,966	11,227	21,501	0	0	8.00
9.00	00900	HOUSEKEEPING	384,014	10,911	20,895	76,881	21,925	9.00
10.00	01000	DIETARY	172,222	78,672	150,664	32,003	43,850	10.00
11.00	01100	CAFETERIA	182,029	7,829	14,993	52,172	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,228,085	38,295	73,338	286,595	51,158	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	35,461	7,779	14,897	9,174	0	14.00
15.00	01500	PHARMACY	8,762,906	15,425	29,540	136,625	43,850	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,536	77,340	148,112	6,436	29,233	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,276,944	141,004	270,035	474,173	87,699	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,743,553	214,546	410,874	389,234	489,653	50.00
51.00	05100	RECOVERY ROOM	164,479	23,670	45,330	41,888	21,925	51.00
53.00	05300	ANESTHESIOLOGY	301,064	1,299	2,488	69,150	73,083	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,379,976	85,552	163,839	263,629	124,241	54.00
60.00	06000	LABORATORY	2,073,058	39,111	74,902	176,245	131,549	60.00
64.00	06400	INTRAVENOUS THERAPY	1,121,233	46,307	88,682	217,934	153,474	64.00
65.00	06500	RESPIRATORY THERAPY	546,214	10,944	20,958	88,529	65,774	65.00
65.01	03610	SLEEP LAB	822,012	48,256	92,415	160,479	292,331	65.01
65.02	03620	GERIATRIC PSYCH	412,173	20,155	38,599	0	36,541	65.02
66.00	06600	PHYSICAL THERAPY	1,082,787	19,989	38,280	203,565	131,549	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	931,810	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,167,061	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	165,364	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	349,051	31,516	60,355	84,901	51,158	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	506,025	42,559	81,505	48,993	95,008	90.00
91.00	09100	EMERGENCY	1,434,580	79,072	151,430	285,665	124,241	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	45,825,704	1,588,724	3,042,542	3,667,595	2,601,745	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,279	13,940	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	17,871	14,808	28,359	0	0	192.00
192.01	19201	UNUSED SPACE	0	7,862	15,057	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	45,843,575	1,618,673	3,099,898	3,667,595	2,601,745	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet B
Part I
Date/Time Prepared:
8/14/2019 12:00 pm

Cost Center Description			PURCHASING RECEIVING AND STORES	CASHIERING/ACC OUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.02	5.03	5A.03	5.04	6.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	114,905					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	986	1,671,632				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	3	0	5,366,641	5,366,641		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	1,536,518	203,719	1,740,237	6.00
7.00	00700	OPERATION OF PLANT	0	0	306,576	40,647	36,093	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	282,694	37,481	17,692	8.00
9.00	00900	HOUSEKEEPING	4	0	514,630	68,232	17,193	9.00
10.00	01000	DIETARY	32	0	477,443	63,302	123,976	10.00
11.00	01100	CAFETERIA	53	0	257,076	34,084	12,337	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,677,381	222,396	60,348	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16	0	67,327	8,927	12,259	14.00
15.00	01500	PHARMACY	2,138	0	8,990,484	1,192,012	24,307	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	274,657	36,415	121,876	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,038	25,359	3,289,252	436,105	222,202	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	52,553	315,104	4,615,517	611,948	338,095	50.00
51.00	05100	RECOVERY ROOM	204	78,274	375,770	49,821	37,301	51.00
53.00	05300	ANESTHESIOLOGY	1,430	52,499	501,013	66,427	2,047	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,868	325,599	2,346,704	311,138	134,817	54.00
60.00	06000	LABORATORY	6,554	265,463	2,766,882	366,847	61,634	60.00
64.00	06400	INTRAVENOUS THERAPY	15,771	36,842	1,680,243	222,775	72,974	64.00
65.00	06500	RESPIRATORY THERAPY	1,200	35,575	769,194	101,984	17,246	65.00
65.01	03610	SLEEP LAB	683	77,507	1,493,683	198,040	76,045	65.01
65.02	03620	GERIATRIC PSYCH	3	4,813	512,284	67,921	31,762	65.02
66.00	06600	PHYSICAL THERAPY	430	51,823	1,528,423	202,646	31,499	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	31,786	963,596	127,758	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	31,230	1,198,291	158,875	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	203,646	369,010	48,925	0	73.00
76.97	07697	CARDIAC REHABILITATION	388	12,321	589,690	78,184	49,664	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,450	33,733	810,273	107,430	67,067	90.00
91.00	09100	EMERGENCY	12,101	90,058	2,177,147	288,657	124,606	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	114,905	1,671,632	45,738,399	5,352,696	1,693,040	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	21,219	2,813	11,471	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	61,038	8,093	23,336	192.00
192.01	19201	UNUSED SPACE	0	0	22,919	3,039	12,390	192.01
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)	114,905	1,671,632	45,843,575	5,366,641	1,740,237	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet B
Part I
Date/Time Prepared:
8/14/2019 12:00 pm

Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	383,316					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,980	341,847				8.00
9.00	00900	HOUSEKEEPING	3,867	341	604,263			9.00
10.00	01000	DIETARY	27,886	175	1,207	693,989		10.00
11.00	01100	CAFETERIA	2,775	0	6,033	0	312,305	11.00
13.00	01300	NURSING ADMINISTRATION	13,574	0	0	0	25,128	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,757	0	0	0	1,795	14.00
15.00	01500	PHARMACY	5,467	0	3,620	0	10,769	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	27,414	0	1,207	0	1,795	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	49,980	91,889	199,777	693,989	52,051	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	76,049	84,601	123,065	0	44,871	50.00
51.00	05100	RECOVERY ROOM	8,390	29,106	4,826	0	3,590	51.00
53.00	05300	ANESTHESIOLOGY	461	0	603	0	5,385	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,325	25,267	24,130	0	30,513	54.00
60.00	06000	LABORATORY	13,863	0	8,446	0	23,333	60.00
64.00	06400	INTRAVENOUS THERAPY	16,414	0	36,195	0	21,538	64.00
65.00	06500	RESPIRATORY THERAPY	3,879	1,242	3,620	0	8,974	65.00
65.01	03610	SLEEP LAB	17,105	1,228	46,752	0	19,743	65.01
65.02	03620	GERIATRIC PSYCH	7,144	0	12,065	0	0	65.02
66.00	06600	PHYSICAL THERAPY	7,085	0	0	0	21,538	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	11,171	1,184	12,065	0	8,974	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	15,086	9,476	48,261	0	5,385	90.00
91.00	09100	EMERGENCY	28,028	97,338	72,391	0	26,923	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	372,700	341,847	604,263	693,989	312,305	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,580	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,249	0	0	0	0	192.00
192.01	19201	UNUSED SPACE	2,787	0	0	0	0	192.01
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)	383,316	341,847	604,263	693,989	312,305	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet B
Part I
Date/Time Prepared:
8/14/2019 12:00 pm

Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			13.00	14.00	15.00	16.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	1,998,827					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	93,065				14.00
15.00	01500	PHARMACY	146,598	0	10,373,257			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	463,364		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	762,852	172	34,830	7,029	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	654,561	87,011	46,414	87,336	0	50.00
51.00	05100	RECOVERY ROOM	55,492	0	1,000	21,695	0	51.00
53.00	05300	ANESTHESIOLOGY	0	16	8,962	14,551	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	190	1,400	90,288	0	54.00
60.00	06000	LABORATORY	0	4	0	73,578	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	586	29,697	10,211	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,459	0	9,860	0	65.00
65.01	03610	SLEEP LAB	0	0	0	21,482	0	65.01
65.02	03620	GERIATRIC PSYCH	0	0	0	1,334	0	65.02
66.00	06600	PHYSICAL THERAPY	0	80	2,391	14,364	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	8,810	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8,656	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	10,220,551	56,444	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	3,415	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	674	8,326	9,350	0	90.00
91.00	09100	EMERGENCY	379,324	873	19,686	24,961	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,998,827	93,065	10,373,257	463,364	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	UNUSED SPACE	0	0	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,998,827	93,065	10,373,257	463,364	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet B
Part I
Date/Time Prepared:
8/14/2019 12:00 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00550	DATA PROCESSING				5.01
5.02	00560	PURCHASING RECEIVING AND STORES				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL				5.04
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
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
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,840,128	0	5,840,128	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,769,468	0	6,769,468	50.00
51.00	05100	RECOVERY ROOM	586,991	0	586,991	51.00
53.00	05300	ANESTHESIOLOGY	599,465	0	599,465	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,994,772	0	2,994,772	54.00
60.00	06000	LABORATORY	3,314,587	0	3,314,587	60.00
64.00	06400	INTRAVENOUS THERAPY	2,090,633	0	2,090,633	64.00
65.00	06500	RESPIRATORY THERAPY	919,458	0	919,458	65.00
65.01	03610	SLEEP LAB	1,874,078	0	1,874,078	65.01
65.02	03620	GERIATRIC PSYCH	632,510	0	632,510	65.02
66.00	06600	PHYSICAL THERAPY	1,808,026	0	1,808,026	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,100,164	0	1,100,164	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,365,822	0	1,365,822	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,694,930	0	10,694,930	73.00
76.97	07697	CARDIAC REHABILITATION	754,347	0	754,347	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,081,328	0	1,081,328	90.00
91.00	09100	EMERGENCY	3,239,934	0	3,239,934	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	45,666,641	0	45,666,641	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	38,083	0	38,083	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	97,716	0	97,716	192.00
192.01	19201	UNUSED SPACE	41,135	0	41,135	192.01
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	45,843,575	0	45,843,575	202.00

COST ALLOCATION STATISTICS

Provider CCN: 14-1334

Period:

From 04/01/2018

To 03/31/2019

Worksheet Non-CMS W

Date/Time Prepared:
8/14/2019 12:00 pm

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4	GROSS SALARIES	4.00
5.01	DATA PROCESSING	24	# OF PC'S	5.01
5.02	PURCHASING RECEIVING AND STORES	25	PURCHASED SUPPLIES	5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE	16	GROSS REVENUE	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	-5	ACCUM. COST	5.04
6.00	MAINTENANCE & REPAIRS	1	SQUARE FEET	6.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	9	HOURS OF SERVICE	9.00
10.00	DIETARY	10	MEALS SERVED	10.00
11.00	CAFETERIA	11	# OF FTE'S	11.00
13.00	NURSING ADMINISTRATION	13	DIRECT NURS. HRS.	13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS.	14.00
15.00	PHARMACY	15	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	16	GROSS REVENUE	16.00
19.00	NONPHYSICIAN ANESTHETISTS	19	ASSIGNED TIME	19.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet B
Part II
Date/Time Prepared:
8/14/2019 12:00 pm

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	15,125	28,965	44,090	4.00
5.01	00550	DATA PROCESSING	0	7,213	13,813	21,026	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	7,129	13,653	20,782	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	21,405	40,992	62,397	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	321,320	615,356	936,676	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	142,170	272,268	414,438	6.00
7.00	00700	OPERATION OF PLANT	0	22,904	43,863	66,767	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	11,227	21,501	32,728	8.00
9.00	00900	HOUSEKEEPING	0	10,911	20,895	31,806	9.00
10.00	01000	DIETARY	0	78,672	150,664	229,336	10.00
11.00	01100	CAFETERIA	0	7,829	14,993	22,822	11.00
13.00	01300	NURSING ADMINISTRATION	0	38,295	73,338	111,633	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,779	14,897	22,676	14.00
15.00	01500	PHARMACY	0	15,425	29,540	44,965	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	77,340	148,112	225,452	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	141,004	270,035	411,039	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	214,546	410,874	625,420	50.00
51.00	05100	RECOVERY ROOM	0	23,670	45,330	69,000	51.00
53.00	05300	ANESTHESIOLOGY	0	1,299	2,488	3,787	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	85,552	163,839	249,391	54.00
60.00	06000	LABORATORY	0	39,111	74,902	114,013	60.00
64.00	06400	INTRAVENOUS THERAPY	0	46,307	88,682	134,989	64.00
65.00	06500	RESPIRATORY THERAPY	0	10,944	20,958	31,902	65.00
65.01	03610	SLEEP LAB	0	48,256	92,415	140,671	65.01
65.02	03620	GERIATRIC PSYCH	0	20,155	38,599	58,754	65.02
66.00	06600	PHYSICAL THERAPY	0	19,989	38,280	58,269	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	31,516	60,355	91,871	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	42,559	81,505	124,064	90.00
91.00	09100	EMERGENCY	0	79,072	151,430	230,502	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,588,724	3,042,542	4,631,266	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,279	13,940	21,219	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	14,808	28,359	43,167	192.00
192.01	19201	UNUSED SPACE	0	7,862	15,057	22,919	192.01
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,618,673	3,099,898	4,718,571	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet B
Part II
Date/Time Prepared:
8/14/2019 12:00 pm

Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	CASHIERING/ACC OUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.01	5.02	5.03	5.04	6.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING	21,026					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	59	20,945				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	945	180	65,341			5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	2,185	1	0	942,261		5.04
6.00	00600	MAINTENANCE & REPAIRS	945	0	0	35,769	452,103	6.00
7.00	00700	OPERATION OF PLANT	177	0	0	7,137	9,377	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	6,581	4,596	8.00
9.00	00900	HOUSEKEEPING	177	1	0	11,980	4,467	9.00
10.00	01000	DIETARY	354	6	0	11,114	32,208	10.00
11.00	01100	CAFETERIA	0	10	0	5,984	3,205	11.00
13.00	01300	NURSING ADMINISTRATION	413	0	0	39,048	15,678	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3	0	1,567	3,185	14.00
15.00	01500	PHARMACY	354	390	0	209,289	6,315	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	236	0	0	6,394	31,663	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	709	2,559	992	76,570	57,727	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,960	9,575	12,327	107,445	87,834	50.00
51.00	05100	RECOVERY ROOM	177	37	3,062	8,748	9,690	51.00
53.00	05300	ANESTHESIOLOGY	591	261	2,054	11,663	532	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,004	705	12,684	54,629	35,025	54.00
60.00	06000	LABORATORY	1,063	1,195	10,385	64,410	16,012	60.00
64.00	06400	INTRAVENOUS THERAPY	1,240	2,875	1,441	39,114	18,958	64.00
65.00	06500	RESPIRATORY THERAPY	532	219	1,392	17,906	4,480	65.00
65.01	03610	SLEEP LAB	2,362	125	3,032	34,771	19,756	65.01
65.02	03620	GERIATRIC PSYCH	295	1	188	11,925	8,252	65.02
66.00	06600	PHYSICAL THERAPY	1,063	78	2,027	35,580	8,183	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,243	22,432	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,222	27,895	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	7,967	8,590	0	73.00
76.97	07697	CARDIAC REHABILITATION	413	71	482	13,727	12,902	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	768	447	1,320	18,862	17,424	90.00
91.00	09100	EMERGENCY	1,004	2,206	3,523	50,682	32,372	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,026	20,945	65,341	939,812	439,841	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	494	2,980	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,421	6,063	192.00
192.01	19201	UNUSED SPACE	0	0	0	534	3,219	192.01
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)	21,026	20,945	65,341	942,261	452,103	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet B
Part II
Date/Time Prepared:
8/14/2019 12:00 pm

Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	83,957					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	872	44,777				8.00
9.00	00900	HOUSEKEEPING	847	45	50,247			9.00
10.00	01000	DIETARY	6,108	23	100	279,634		10.00
11.00	01100	CAFETERIA	608	0	502	0	33,758	11.00
13.00	01300	NURSING ADMINISTRATION	2,973	0	0	0	2,716	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	604	0	0	0	194	14.00
15.00	01500	PHARMACY	1,198	0	301	0	1,164	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,004	0	100	0	194	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,947	12,036	16,613	279,634	5,628	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	16,656	11,081	10,233	0	4,850	50.00
51.00	05100	RECOVERY ROOM	1,838	3,813	401	0	388	51.00
53.00	05300	ANESTHESIOLOGY	101	0	50	0	582	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,642	3,310	2,007	0	3,298	54.00
60.00	06000	LABORATORY	3,036	0	702	0	2,522	60.00
64.00	06400	INTRAVENOUS THERAPY	3,595	0	3,010	0	2,328	64.00
65.00	06500	RESPIRATORY THERAPY	850	163	301	0	970	65.00
65.01	03610	SLEEP LAB	3,746	161	3,888	0	2,134	65.01
65.02	03620	GERIATRIC PSYCH	1,565	0	1,003	0	0	65.02
66.00	06600	PHYSICAL THERAPY	1,552	0	0	0	2,328	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	2,447	155	1,003	0	970	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,304	1,241	4,013	0	582	90.00
91.00	09100	EMERGENCY	6,139	12,749	6,020	0	2,910	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	81,632	44,777	50,247	279,634	33,758	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	565	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,150	0	0	0	0	192.00
192.01	19201	UNUSED SPACE	610	0	0	0	0	192.01
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)	83,957	44,777	50,247	279,634	33,758	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet B
Part II
Date/Time Prepared:
8/14/2019 12:00 pm

Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			13.00	14.00	15.00	16.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	175,905					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	28,339				14.00
15.00	01500	PHARMACY	12,901	0	278,519			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	270,120		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	67,134	52	935	4,098		30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	57,604	26,496	1,246	50,919		50.00
51.00	05100	RECOVERY ROOM	4,884	0	27	12,649		51.00
53.00	05300	ANESTHESIOLOGY	0	5	241	8,484		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	58	38	52,606		54.00
60.00	06000	LABORATORY	0	1	0	42,898		60.00
64.00	06400	INTRAVENOUS THERAPY	0	179	797	5,954		64.00
65.00	06500	RESPIRATORY THERAPY	0	1,053	0	5,749		65.00
65.01	03610	SLEEP LAB	0	0	0	12,525		65.01
65.02	03620	GERIATRIC PSYCH	0	0	0	778		65.02
66.00	06600	PHYSICAL THERAPY	0	24	64	8,374		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	5,136		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,047		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	274,418	32,908		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,991		76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	205	224	5,451		90.00
91.00	09100	EMERGENCY	33,382	266	529	14,553		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	175,905	28,339	278,519	270,120	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	19201	UNUSED SPACE	0	0	0	0		192.01
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)	175,905	28,339	278,519	270,120	0	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet B
Part II
Date/Time Prepared:
8/14/2019 12:00 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00550	DATA PROCESSING				5.01
5.02	00560	PURCHASING RECEIVING AND STORES				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL				5.04
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
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
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	952,378	0	952,378	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,030,325	0	1,030,325	50.00
51.00	05100	RECOVERY ROOM	115,217	0	115,217	51.00
53.00	05300	ANESTHESIOLOGY	29,182	0	29,182	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	424,566	0	424,566	54.00
60.00	06000	LABORATORY	258,355	0	258,355	60.00
64.00	06400	INTRAVENOUS THERAPY	217,100	0	217,100	64.00
65.00	06500	RESPIRATORY THERAPY	66,581	0	66,581	65.00
65.01	03610	SLEEP LAB	225,100	0	225,100	65.01
65.02	03620	GERIATRIC PSYCH	82,761	0	82,761	65.02
66.00	06600	PHYSICAL THERAPY	119,989	0	119,989	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	28,811	0	28,811	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	34,164	0	34,164	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	323,883	0	323,883	73.00
76.97	07697	CARDIAC REHABILITATION	127,053	0	127,053	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	178,494	0	178,494	90.00
91.00	09100	EMERGENCY	400,271	0	400,271	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,614,230	0	4,614,230	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	25,258	0	25,258	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	51,801	0	51,801	192.00
192.01	19201	UNUSED SPACE	27,282	0	27,282	192.01
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,718,571	0	4,718,571	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1334

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

Worksheet B-1

Date/Time Prepared:
8/14/2019 12:00 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (# OF PC'S)	PURCHASING RECEIVING AND STORES (PURCHASED SUPPLIES)	
			BLDG & FIXT (SQUARE FEET)	MOVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	97,175					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		97,175				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	908	908	14,075,619			4.00
5.01	00550	DATA PROCESSING	433	433	0	356		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	428	428	33,056	1	1,443,138	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,285	1,285	580,850	16	12,384	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	19,290	19,290	1,085,254	37	40	5.04
6.00	00600	MAINTENANCE & REPAIRS	8,535	8,535	303,683	16	0	6.00
7.00	00700	OPERATION OF PLANT	1,375	1,375	159,444	3	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	674	674	0	0	0	8.00
9.00	00900	HOUSEKEEPING	655	655	295,055	3	47	9.00
10.00	01000	DIETARY	4,723	4,723	122,821	6	405	10.00
11.00	01100	CAFETERIA	470	470	200,227	0	660	11.00
13.00	01300	NURSING ADMINISTRATION	2,299	2,299	1,099,557	7	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	467	467	35,207	0	203	14.00
15.00	01500	PHARMACY	926	926	524,344	6	26,858	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,643	4,643	24,700	4	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,465	8,465	1,819,812	12	176,311	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,880	12,880	1,493,812	67	660,028	50.00
51.00	05100	RECOVERY ROOM	1,421	1,421	160,758	3	2,562	51.00
53.00	05300	ANESTHESIOLOGY	78	78	265,384	10	17,961	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,136	5,136	1,011,763	17	48,574	54.00
60.00	06000	LABORATORY	2,348	2,348	676,398	18	82,319	60.00
64.00	06400	INTRAVENOUS THERAPY	2,780	2,780	836,394	21	198,069	64.00
65.00	06500	RESPIRATORY THERAPY	657	657	339,761	9	15,068	65.00
65.01	03610	SLEEP LAB	2,897	2,897	615,892	40	8,579	65.01
65.02	03620	GERIATRIC PSYCH	1,210	1,210	0	5	42	65.02
66.00	06600	PHYSICAL THERAPY	1,200	1,200	781,249	18	5,398	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	1,892	1,892	325,836	7	4,876	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,555	2,555	188,027	13	30,772	90.00
91.00	09100	EMERGENCY	4,747	4,747	1,096,335	17	151,982	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	95,377	95,377	14,075,619	356	1,443,138	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	437	437	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	889	889	0	0	0	192.00
192.01	19201	UNUSED SPACE	472	472	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,618,673	3,099,898	3,667,595	2,601,745	114,905	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.657299	31.900160	0.260564	7,308.272472	0.079622	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			44,090	21,026	20,945	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.003132	59.061798	0.014514	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: 14-1334

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

Worksheet B-1

Date/Time Prepared:
8/14/2019 12:00 pm

Cost Center Description			CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	
			5.03	5A.04	5.04	6.00	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	213,720,098					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	-5,366,641	40,476,934			5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	1,536,518	66,296		6.00
7.00	00700	OPERATION OF PLANT	0	0	306,576	1,375	64,921	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	282,694	674	674	8.00
9.00	00900	HOUSEKEEPING	0	0	514,630	655	655	9.00
10.00	01000	DIETARY	0	0	477,443	4,723	4,723	10.00
11.00	01100	CAFETERIA	0	0	257,076	470	470	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,677,381	2,299	2,299	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	67,327	467	467	14.00
15.00	01500	PHARMACY	0	0	8,990,484	926	926	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	274,657	4,643	4,643	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,242,054	0	3,289,252	8,465	8,465	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	40,284,273	0	4,615,517	12,880	12,880	50.00
51.00	05100	RECOVERY ROOM	10,006,870	0	375,770	1,421	1,421	51.00
53.00	05300	ANESTHESIOLOGY	6,711,751	0	501,013	78	78	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,637,182	0	2,346,704	5,136	5,136	54.00
60.00	06000	LABORATORY	33,937,993	0	2,766,882	2,348	2,348	60.00
64.00	06400	INTRAVENOUS THERAPY	4,710,072	0	1,680,243	2,780	2,780	64.00
65.00	06500	RESPIRATORY THERAPY	4,548,059	0	769,194	657	657	65.00
65.01	03610	SLEEP LAB	9,908,787	0	1,493,683	2,897	2,897	65.01
65.02	03620	GERIATRIC PSYCH	615,372	0	512,284	1,210	1,210	65.02
66.00	06600	PHYSICAL THERAPY	6,625,310	0	1,528,423	1,200	1,200	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,063,637	0	963,596	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,992,621	0	1,198,291	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,035,052	0	369,010	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	1,575,131	0	589,690	1,892	1,892	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	4,312,539	0	810,273	2,555	2,555	90.00
91.00	09100	EMERGENCY	11,513,395	0	2,177,147	4,747	4,747	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	213,720,098	-5,366,641	40,371,758	64,498	63,123	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	21,219	437	437	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	61,038	889	889	192.00
192.01	19201	UNUSED SPACE	0	0	22,919	472	472	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,671,632		5,366,641	1,740,237	383,316	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.007822		0.132585	26.249502	5.904345	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	65,341		942,261	452,103	83,957	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000306		0.023279	6.819461	1.293218	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: 14-1334

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

Worksheet B-1

Date/Time Prepared:
8/14/2019 12:00 pm

Cost Center Description			LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (# OF FTE'S)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
			8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	70,163					8.00
9.00	00900	HOUSEKEEPING	70	6,010				9.00
10.00	01000	DIETARY	36	12	18,801			10.00
11.00	01100	CAFETERIA	0	60	0	174		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	14	157,372	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	1	0	14.00
15.00	01500	PHARMACY	0	36	0	6	11,542	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12	0	1	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,860	1,987	18,801	29	60,061	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	17,364	1,224	0	25	51,535	50.00
51.00	05100	RECOVERY ROOM	5,974	48	0	2	4,369	51.00
53.00	05300	ANESTHESIOLOGY	0	6	0	3	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,186	240	0	17	0	54.00
60.00	06000	LABORATORY	0	84	0	13	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	360	0	12	0	64.00
65.00	06500	RESPIRATORY THERAPY	255	36	0	5	0	65.00
65.01	03610	SLEEP LAB	252	465	0	11	0	65.01
65.02	03620	GERIATRIC PSYCH	0	120	0	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0	0	0	12	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	243	120	0	5	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,945	480	0	3	0	90.00
91.00	09100	EMERGENCY	19,978	720	0	15	29,865	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	70,163	6,010	18,801	174	157,372	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	UNUSED SPACE	0	0	0	0	0	192.01
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)	341,847	604,263	693,989	312,305	1,998,827	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.872183	100.542928	36.912345	1,794.856322	12.701287	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	44,777	50,247	279,634	33,758	175,905	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.638185	8.360566	14.873358	194.011494	1.117766	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: 14-1334

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

Worksheet B-1

Date/Time Prepared:
8/14/2019 12:00 pm

Cost Center Description			CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			14.00	15.00	16.00	19.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	DATA PROCESSING					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	931,639				14.00
15.00	01500	PHARMACY	0	8,039,607			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	213,720,098		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,717	26,994	3,242,054	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	871,037	35,972	40,284,273	0	50.00
51.00	05100	RECOVERY ROOM	0	775	10,006,870	0	51.00
53.00	05300	ANESTHESIOLOGY	164	6,946	6,711,751	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,899	1,085	41,637,182	0	54.00
60.00	06000	LABORATORY	41	0	33,937,993	0	60.00
64.00	06400	INTRAVENOUS THERAPY	5,870	23,016	4,710,072	0	64.00
65.00	06500	RESPIRATORY THERAPY	34,631	0	4,548,059	0	65.00
65.01	03610	SLEEP LAB	0	0	9,908,787	0	65.01
65.02	03620	GERIATRIC PSYCH	0	0	615,372	0	65.02
66.00	06600	PHYSICAL THERAPY	801	1,853	6,625,310	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	4,063,637	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	3,992,621	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,921,256	26,035,052	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	1,575,131	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	6,744	6,453	4,312,539	0	90.00
91.00	09100	EMERGENCY	8,735	15,257	11,513,395	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	931,639	8,039,607	213,720,098	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	UNUSED SPACE	0	0	0	0	192.01
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)	93,065	10,373,257	463,364	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.099894	1.290269	0.002168	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	28,339	278,519	270,120	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.030418	0.034643	0.001264	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet C
Part I
Date/Time Prepared:
8/14/2019 12:00 pm

		Title XVIII		Hospital	Cost	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	5,840,128		5,840,128	0	0 30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	6,769,468		6,769,468	0	0 50.00
51.00	05100 RECOVERY ROOM	586,991		586,991	0	0 51.00
53.00	05300 ANESTHESIOLOGY	599,465		599,465	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,994,772		2,994,772	0	0 54.00
60.00	06000 LABORATORY	3,314,587		3,314,587	0	0 60.00
64.00	06400 INTRAVENOUS THERAPY	2,090,633		2,090,633	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	919,458	0	919,458	0	0 65.00
65.01	03610 SLEEP LAB	1,874,078	0	1,874,078	0	0 65.01
65.02	03620 GERIATRIC PSYCH	632,510	0	632,510	0	0 65.02
66.00	06600 PHYSICAL THERAPY	1,808,026	0	1,808,026	0	0 66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,100,164		1,100,164	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,365,822		1,365,822	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	10,694,930		10,694,930	0	0 73.00
76.97	07697 CARDIAC REHABILITATION	754,347		754,347	0	0 76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	1,081,328		1,081,328	0	0 90.00
91.00	09100 EMERGENCY	3,239,934		3,239,934	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	439,319		439,319		0 92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	46,105,960	0	46,105,960	0	0 200.00
201.00	Less Observation Beds	439,319		439,319		0 201.00
202.00	Total (see instructions)	45,666,641	0	45,666,641	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet C
Part I
Date/Time Prepared:
8/14/2019 12:00 pm

			Title XVIII		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	2,654,460		2,654,460		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	696,511	38,405,403	39,101,914	0.173124	0.000000
51.00	05100	RECOVERY ROOM	78,680	9,610,292	9,688,972	0.060583	0.000000
53.00	05300	ANESTHESIOLOGY	104,017	6,377,612	6,481,629	0.092487	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	962,410	39,439,954	40,402,364	0.074124	0.000000
60.00	06000	LABORATORY	1,402,865	31,165,365	32,568,230	0.101774	0.000000
64.00	06400	INTRAVENOUS THERAPY	80,449	4,491,921	4,572,370	0.457232	0.000000
65.00	06500	RESPIRATORY THERAPY	1,140,777	3,354,107	4,494,884	0.204557	0.000000
65.01	03610	SLEEP LAB	0	9,466,738	9,466,738	0.197964	0.000000
65.02	03620	GERIATRIC PSYCH	0	615,372	615,372	1.027850	0.000000
66.00	06600	PHYSICAL THERAPY	2,042,801	4,394,342	6,437,143	0.280874	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	112,076	3,882,026	3,994,102	0.275447	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	91,472	3,865,202	3,956,674	0.345194	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	2,578,869	22,496,904	25,075,773	0.426504	0.000000
76.97	07697	CARDIAC REHABILITATION	0	1,546,440	1,546,440	0.487796	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,093	4,283,974	4,286,067	0.252289	0.000000
91.00	09100	EMERGENCY	218,776	11,109,505	11,328,281	0.286004	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	15,739	569,131	584,870	0.751140	0.000000
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	12,181,995	195,074,288	207,256,283		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	12,181,995	195,074,288	207,256,283		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet C
Part I
Date/Time Prepared:
8/14/2019 12:00 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
65.01	03610 SLEEP LAB	0.000000			65.01
65.02	03620 GERIATRIC PSYCH	0.000000			65.02
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 PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
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: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet C
Part I
Date/Time Prepared:
8/14/2019 12:00 pm

			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	5,840,128		5,840,128	0	5,840,128	30.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,769,468		6,769,468	0	6,769,468	50.00	
51.00	05100	RECOVERY ROOM	586,991		586,991	0	586,991	51.00	
53.00	05300	ANESTHESIOLOGY	599,465		599,465	0	599,465	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,994,772		2,994,772	0	2,994,772	54.00	
60.00	06000	LABORATORY	3,314,587		3,314,587	0	3,314,587	60.00	
64.00	06400	INTRAVENOUS THERAPY	2,090,633		2,090,633	0	2,090,633	64.00	
65.00	06500	RESPIRATORY THERAPY	919,458	0	919,458	0	919,458	65.00	
65.01	03610	SLEEP LAB	1,874,078	0	1,874,078	0	1,874,078	65.01	
65.02	03620	GERIATRIC PSYCH	632,510	0	632,510	0	632,510	65.02	
66.00	06600	PHYSICAL THERAPY	1,808,026	0	1,808,026	0	1,808,026	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,100,164		1,100,164	0	1,100,164	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,365,822		1,365,822	0	1,365,822	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	10,694,930		10,694,930	0	10,694,930	73.00	
76.97	07697	CARDIAC REHABILITATION	754,347		754,347	0	754,347	76.97	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,081,328		1,081,328	0	1,081,328	90.00	
91.00	09100	EMERGENCY	3,239,934		3,239,934	0	3,239,934	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	439,319		439,319		439,319	92.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	46,105,960	0	46,105,960	0	46,105,960	200.00	
201.00		Less Observation Beds	439,319		439,319		439,319	201.00	
202.00		Total (see instructions)	45,666,641	0	45,666,641	0	45,666,641	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet C
Part I
Date/Time Prepared:
8/14/2019 12:00 pm

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,654,460		2,654,460		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	696,511	38,405,403	39,101,914	0.173124	0.000000
51.00	05100	RECOVERY ROOM	78,680	9,610,292	9,688,972	0.060583	0.000000
53.00	05300	ANESTHESIOLOGY	104,017	6,377,612	6,481,629	0.092487	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	962,410	39,439,954	40,402,364	0.074124	0.000000
60.00	06000	LABORATORY	1,402,865	31,165,365	32,568,230	0.101774	0.000000
64.00	06400	INTRAVENOUS THERAPY	80,449	4,491,921	4,572,370	0.457232	0.000000
65.00	06500	RESPIRATORY THERAPY	1,140,777	3,354,107	4,494,884	0.204557	0.000000
65.01	03610	SLEEP LAB	0	9,466,738	9,466,738	0.197964	0.000000
65.02	03620	GERIATRIC PSYCH	0	615,372	615,372	1.027850	0.000000
66.00	06600	PHYSICAL THERAPY	2,042,801	4,394,342	6,437,143	0.280874	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	112,076	3,882,026	3,994,102	0.275447	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	91,472	3,865,202	3,956,674	0.345194	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	2,578,869	22,496,904	25,075,773	0.426504	0.000000
76.97	07697	CARDIAC REHABILITATION	0	1,546,440	1,546,440	0.487796	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,093	4,283,974	4,286,067	0.252289	0.000000
91.00	09100	EMERGENCY	218,776	11,109,505	11,328,281	0.286004	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	15,739	569,131	584,870	0.751140	0.000000
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	12,181,995	195,074,288	207,256,283		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	12,181,995	195,074,288	207,256,283		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet C
Part I
Date/Time Prepared:
8/14/2019 12:00 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
65.01	03610 SLEEP LAB	0.000000			65.01
65.02	03620 GERIATRIC PSYCH	0.000000			65.02
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 PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
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 ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet D
Part II
Date/Time Prepared:
8/14/2019 12:00 pm

Cost Center Description			Title XVIII		Hospital	Cost	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,030,325	39,101,914	0.026350	447,667	11,796
51.00	05100	RECOVERY ROOM	115,217	9,688,972	0.011892	50,904	605
53.00	05300	ANESTHESIOLOGY	29,182	6,481,629	0.004502	66,388	299
54.00	05400	RADIOLOGY-DIAGNOSTIC	424,566	40,402,364	0.010508	427,007	4,487
60.00	06000	LABORATORY	258,355	32,568,230	0.007933	416,096	3,301
64.00	06400	INTRAVENOUS THERAPY	217,100	4,572,370	0.047481	31,682	1,504
65.00	06500	RESPIRATORY THERAPY	66,581	4,494,884	0.014813	231,378	3,427
65.01	03610	SLEEP LAB	225,100	9,466,738	0.023778	0	0
65.02	03620	GERIATRIC PSYCH	82,761	615,372	0.134489	0	0
66.00	06600	PHYSICAL THERAPY	119,989	6,437,143	0.018640	99,646	1,857
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	28,811	3,994,102	0.007213	92,185	665
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	34,164	3,956,674	0.008635	23,850	206
73.00	07300	DRUGS CHARGED TO PATIENTS	323,883	25,075,773	0.012916	500,862	6,469
76.97	07697	CARDIAC REHABILITATION	127,053	1,546,440	0.082158	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	178,494	4,286,067	0.041645	1,540	64
91.00	09100	EMERGENCY	400,271	11,328,281	0.035334	2,821	100
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	71,642	584,870	0.122492	2,338	286
200.00		Total (lines 50 through 199)	3,733,494	204,601,823		2,394,364	35,066

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1334

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

Worksheet D
Part IV
Date/Time Prepared:
8/14/2019 12:00 pm

Cost Center Description			Title XVIII		Hospital		Cost	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	03610	SLEEP LAB	0	0	0	0	0	65.01
65.02	03620	GERIATRIC PSYCH	0	0	0	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/14/2019 12:00 pm

Cost Center Description			Title XVIII		Hospital	Cost		
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
				4.00	5.00	6.00	7.00	8.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	39,101,914	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	9,688,972	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	6,481,629	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	40,402,364	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	32,568,230	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	4,572,370	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,494,884	0.000000	65.00
65.01	03610	SLEEP LAB	0	0	0	9,466,738	0.000000	65.01
65.02	03620	GERIATRIC PSYCH	0	0	0	615,372	0.000000	65.02
66.00	06600	PHYSICAL THERAPY	0	0	0	6,437,143	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,994,102	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,956,674	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	25,075,773	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,546,440	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	4,286,067	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	11,328,281	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	584,870	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	204,601,823		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1334

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

Worksheet D
Part IV
Date/Time Prepared:
8/14/2019 12:00 pm

Cost Center Description		Title XVIII			Hospital		Cost	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	447,667	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	50,904	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	66,388	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	427,007	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	416,096	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	31,682	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	231,378	0	0	0	65.00
65.01	03610	SLEEP LAB	0.000000	0	0	0	0	65.01
65.02	03620	GERIATRIC PSYCH	0.000000	0	0	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0.000000	99,646	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	92,185	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	23,850	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	500,862	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	1,540	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	2,821	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	2,338	0	0	0	92.00
200.00		Total (lines 50 through 199)		2,394,364	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/14/2019 12:00 pm

				Title XVIII		Hospital		Cost	
Cost Center Description			PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost					
			21.00	24.00					
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0					50.00
51.00	05100	RECOVERY ROOM	0	0					51.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
60.00	06000	LABORATORY	0	0					60.00
64.00	06400	INTRAVENOUS THERAPY	0	0					64.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
65.01	03610	SLEEP LAB	0	0					65.01
65.02	03620	GERIATRIC PSYCH	0	0					65.02
66.00	06600	PHYSICAL THERAPY	0	0					66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					73.00
76.97	07697	CARDIAC REHABILITATION	0	0					76.97
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0					90.00
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0					92.00
200.00		Total (lines 50 through 199)	0	0					200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet D
Part V
Date/Time Prepared:
8/14/2019 12:00 pm

			Title XVIII		Hospital		Cost	
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	0.173124	0	12,019,415	0	0	50.00
51.00	05100	RECOVERY ROOM	0.060583	0	3,216,530	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.092487	0	2,005,056	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.074124	0	13,814,872	0	0	54.00
60.00	06000	LABORATORY	0.101774	0	9,571,834	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.457232	0	1,869,306	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.204557	0	1,068,572	0	0	65.00
65.01	03610	SLEEP LAB	0.197964	0	2,763,385	0	0	65.01
65.02	03620	GERIATRIC PSYCH	1.027850	0	446,969	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0.280874	0	1,313,690	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.275447	0	1,642,402	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.345194	0	1,541,814	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.426504	0	10,467,566	1,503	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.487796	0	563,607	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.252289	0	1,918,729	0	0	90.00
91.00	09100	EMERGENCY	0.286004	0	3,316,499	1,376	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.751140	0	431,179	0	0	92.00
200.00		Subtotal (see instructions)		0	67,971,425	2,879	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	67,971,425	2,879	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet D
Part V
Date/Time Prepared:
8/14/2019 12:00 pm

			Title XVIII	Hospital	Cost
	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	2,080,849	0	50.00
51.00	05100	RECOVERY ROOM	194,867	0	51.00
53.00	05300	ANESTHESIOLOGY	185,442	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,024,014	0	54.00
60.00	06000	LABORATORY	974,164	0	60.00
64.00	06400	INTRAVENOUS THERAPY	854,707	0	64.00
65.00	06500	RESPIRATORY THERAPY	218,584	0	65.00
65.01	03610	SLEEP LAB	547,051	0	65.01
65.02	03620	GERIATRIC PSYCH	459,417	0	65.02
66.00	06600	PHYSICAL THERAPY	368,981	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	452,395	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	532,225	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,464,459	641	73.00
76.97	07697	CARDIAC REHABILITATION	274,925	0	76.97
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	484,074	0	90.00
91.00	09100	EMERGENCY	948,532	394	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	323,876	0	92.00
200.00		Subtotal (see instructions)	14,388,562	1,035	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	14,388,562	1,035	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1334

Period:

Worksheet D

Component CCN: 14-Z334

From 04/01/2018
To 03/31/2019Part V
Date/Time Prepared:
8/14/2019 12:00 pm

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Title XVIII		Swing Beds - SNF		Cost	
			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	0.173124	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.060583	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.092487	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.074124	0	0	0	0	54.00
60.00	06000	LABORATORY	0.101774	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.457232	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.204557	0	0	0	0	65.00
65.01	03610	SLEEP LAB	0.197964	0	0	0	0	65.01
65.02	03620	GERIATRIC PSYCH	1.027850	0	0	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0.280874	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.275447	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.345194	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.426504	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.487796	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.252289	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.286004	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.751140	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1334

Period:

Worksheet D

Component CCN: 14-Z334

From 04/01/2018
To 03/31/2019Part V
Date/Time Prepared:
8/14/2019 12:00 pm

			Title XVIII		Swing Beds - SNF		Cost	
Cost Center Description	Costs							
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)						
	6.00	7.00						
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0			50.00	
51.00	05100	RECOVERY ROOM	0	0			51.00	
53.00	05300	ANESTHESIOLOGY	0	0			53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0			54.00	
60.00	06000	LABORATORY	0	0			60.00	
64.00	06400	INTRAVENOUS THERAPY	0	0			64.00	
65.00	06500	RESPIRATORY THERAPY	0	0			65.00	
65.01	03610	SLEEP LAB	0	0			65.01	
65.02	03620	GERIATRIC PSYCH	0	0			65.02	
66.00	06600	PHYSICAL THERAPY	0	0			66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0			73.00	
76.97	07697	CARDIAC REHABILITATION	0	0			76.97	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0			90.00	
91.00	09100	EMERGENCY	0	0			91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00	
200.00		Subtotal (see instructions)	0	0			200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0				201.00	
202.00		Net Charges (line 200 - line 201)	0	0			202.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1334	Period: From 04/01/2018 To 03/31/2019	Worksheet D-1 Date/Time Prepared: 8/14/2019 12:00 pm
Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			4,898 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,331 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)			983 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			2,511 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)			746 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			105 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)			205 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			575 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)			1,401 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)			411 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			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			155.23 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			155.23 20.00
21.00	Total general inpatient routine service cost (see instructions)			5,840,128 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)			16,299 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)			31,822 25.00
26.00	Total swing-bed cost (see instructions)			4,159,856 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,680,272 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)			1,680,272 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)			1,262.43 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			725,897 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)			725,897 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1334

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

Worksheet D-1

Date/Time Prepared:
8/14/2019 12:00 pm

		Title XVIII		Hospital	Cost	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)					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)					500,726 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,226,623 49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0 54.00
55.00	Target amount per discharge					0.00 55.00
56.00	Target amount (line 54 x line 55)					0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00	Bonus payment (see instructions)					0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00	Relief payment (see instructions)					0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					1,768,664 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					518,859 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					2,287,523 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)					348 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,262.41 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					439,319 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1334

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

Worksheet D-1

Date/Time Prepared:
8/14/2019 12:00 pm

Cost Center Description		Title XVIII		Hospital		Cost	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	952,378	5,840,128	0.163075	439,319	71,642	90.00
91.00	Nursing School cost	0	5,840,128	0.000000	439,319	0	91.00
92.00	Allied health cost	0	5,840,128	0.000000	439,319	0	92.00
93.00	All other Medical Education	0	5,840,128	0.000000	439,319	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1334	Period: From 04/01/2018 To 03/31/2019	Worksheet D-3 Date/Time Prepared: 8/14/2019 12:00 pm	
Cost Center Description		Title XVIII	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		465,750		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.173124	447,667	77,502	50.00
51.00	05100 RECOVERY ROOM	0.060583	50,904	3,084	51.00
53.00	05300 ANESTHESIOLOGY	0.092487	66,388	6,140	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.074124	427,007	31,651	54.00
60.00	06000 LABORATORY	0.101774	416,096	42,348	60.00
64.00	06400 INTRAVENOUS THERAPY	0.457232	31,682	14,486	64.00
65.00	06500 RESPIRATORY THERAPY	0.204557	231,378	47,330	65.00
65.01	03610 SLEEP LAB	0.197964	0	0	65.01
65.02	03620 GERIATRIC PSYCH	1.027850	0	0	65.02
66.00	06600 PHYSICAL THERAPY	0.280874	99,646	27,988	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.275447	92,185	25,392	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.345194	23,850	8,233	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.426504	500,862	213,620	73.00
76.97	07697 CARDIAC REHABILITATION	0.487796	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.252289	1,540	389	90.00
91.00	09100 EMERGENCY	0.286004	2,821	807	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.751140	2,338	1,756	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2,394,364	500,726	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)		2,394,364		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1334 Component CCN: 14-Z334	Period: From 04/01/2018 To 03/31/2019	Worksheet D-3 Date/Time Prepared: 8/14/2019 12:00 pm	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.173124	0	0	50.00
51.00	05100 RECOVERY ROOM	0.060583	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.092487	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.074124	125,653	9,314	54.00
60.00	06000 LABORATORY	0.101774	251,065	25,552	60.00
64.00	06400 INTRAVENOUS THERAPY	0.457232	5,355	2,448	64.00
65.00	06500 RESPIRATORY THERAPY	0.204557	259,233	53,028	65.00
65.01	03610 SLEEP LAB	0.197964	0	0	65.01
65.02	03620 GERIATRIC PSYCH	1.027850	0	0	65.02
66.00	06600 PHYSICAL THERAPY	0.280874	1,000,601	281,043	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.275447	5,342	1,471	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.345194	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.426504	826,990	352,715	73.00
76.97	07697 CARDIAC REHABILITATION	0.487796	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.252289	553	140	90.00
91.00	09100 EMERGENCY	0.286004	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.751140	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2,474,792	725,711	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		2,474,792		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1334 Component CCN: 14-Z334	Period: From 04/01/2018 To 03/31/2019	Worksheet D-3 Date/Time Prepared: 8/14/2019 12:00 pm	
Cost Center Description		Title XIX	Swing Beds - SNF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.173124	0	0	50.00
51.00	05100 RECOVERY ROOM	0.060583	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.092487	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.074124	0	0	54.00
60.00	06000 LABORATORY	0.101774	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.457232	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.204557	0	0	65.00
65.01	03610 SLEEP LAB	0.197964	0	0	65.01
65.02	03620 GERIATRIC PSYCH	1.027850	0	0	65.02
66.00	06600 PHYSICAL THERAPY	0.280874	0	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.275447	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.345194	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.426504	0	0	73.00
76.97	07697 CARDIAC REHABILITATION	0.487796	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.252289	0	0	90.00
91.00	09100 EMERGENCY	0.286004	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.751140	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1334	Period: From 04/01/2018 To 03/31/2019	Worksheet E Part B Date/Time Prepared: 8/14/2019 12:00 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		14,389,597	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		14,389,597	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	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)		0	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)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	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)		14,533,493	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)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		118,076	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		11,842,478	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		2,572,939	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,572,939	30.00
31.00	Primary payer payments		1,478	31.00
32.00	Subtotal (line 30 minus line 31)		2,571,461	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)		2,185,777	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		1,420,755	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,354,156	36.00
37.00	Subtotal (see instructions)		3,992,216	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,992,216	40.00
40.01	Sequestration adjustment (see instructions)		79,844	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		3,902,254	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		10,118	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1334	Period: From 04/01/2018 To 03/31/2019	Worksheet E Part B Date/Time Prepared: 8/14/2019 12:00 pm
		Title XVIII	Hospital	Cost
				Overrides
				1.00
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)			0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet E-1
Part I
Date/Time Prepared:
8/14/2019 12:00 pm

		Title XVIII		Hospital		Cost
		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		1,210,152		5,379,335	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	09/21/2018	107,035	3.01
3.02		03/28/2019	7,895	10/10/2018	82,531	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	09/21/2018	118,368	03/28/2019	1,666,647	3.50
3.51		10/10/2018	39,154		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)		-149,627		-1,477,081	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)		1,060,525		3,902,254	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		11,385		10,118	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,071,910		3,912,372	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: 14-1334
 Component CCN: 14-Z334

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

 Worksheet E-1
 Part I
 Date/Time Prepared:
 8/14/2019 12:00 pm

		Title XVIII		Swing Beds - SNF		Cost	
		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		2,880,590		0	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	09/21/2018	46,775		0	3.01	
3.02		10/10/2018	1,744		0	3.02	
3.03		03/28/2019	63,716		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)		112,235		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)		2,992,825		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		63,568		0	6.02	
7.00	Total Medicare program liability (see instructions)		2,929,257		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: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet E-1
Part II
Date/Time Prepared:
8/14/2019 12:00 pm

		Title XVIII	Hospital	Cost
				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
				Overrides
				1.00
	CONTRACTOR OVERRIDES			
108.00	Override of HIT payment			108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1334

Period:

Worksheet E-2

Component CCN: 14-Z334

From 04/01/2018
To 03/31/2019Date/Time Prepared:
8/14/2019 12:00 pm

		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		2,310,398	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)		732,968	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		1,812	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		3,043,366	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		3,043,366	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		3,043,366	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		54,328	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		2,989,038	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		2,989,038	0	19.00
19.01	Sequestration adjustment (see instructions)		59,781	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
20.00	Interim payments		2,992,825	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		-63,568	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1334

Period:

Worksheet E-2

Component CCN: 14-Z334

From 04/01/2018
To 03/31/2019Date/Time Prepared:
8/14/2019 12:00 pm

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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1334	Period: From 04/01/2018 To 03/31/2019	Worksheet E-3 Part V Date/Time Prepared: 8/14/2019 12:00 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,226,623	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		1,226,623	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,238,889	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		1,238,889	19.00
20.00	Deductibles (exclude professional component)		199,307	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,039,582	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,039,582	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		83,391	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		54,204	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		51,881	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,093,786	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		1,093,786	30.00
30.01	Sequestration adjustment (see instructions)		21,876	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
31.00	Interim payments		1,060,525	31.00
32.00	Tentative settlement (for contractor use only)		0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		11,385	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

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

Provider CCN: 14-1334

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

Worksheet G

Date/Time Prepared:
8/14/2019 12:00 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	68,091	0	17,066	0	1.00
2.00	Temporary investments	24,000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	43,811,537	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-27,756,375	0	0	0	6.00
7.00	Inventory	1,495,415	0	0	0	7.00
8.00	Prepaid expenses	84,953	0	0	0	8.00
9.00	Other current assets	105,722	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	17,833,343	0	17,066	0	11.00
FIXED ASSETS						
12.00	Land	171,136	0	0	0	12.00
13.00	Land improvements	1,133,915	0	0	0	13.00
14.00	Accumulated depreciation	-803,923	0	0	0	14.00
15.00	Buildings	28,781,217	0	0	0	15.00
16.00	Accumulated depreciation	-14,605,258	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	148,889	0	0	0	21.00
22.00	Accumulated depreciation	-76,058	0	0	0	22.00
23.00	Major movable equipment	16,208,610	0	0	0	23.00
24.00	Accumulated depreciation	-10,459,150	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	332,958	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	20,832,336	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	98,947	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	98,947	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	38,764,626	0	17,066	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,859,973	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,800,745	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	298,105	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	1,959,805	0	0	0	43.00
44.00	Other current liabilities	334,867	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,253,495	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	14,609,817	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	259,156	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	14,868,973	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	22,122,468	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	16,642,158	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	17,066	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	16,642,158	0	17,066	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	38,764,626	0	17,066	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1334

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

Worksheet G-1

Date/Time Prepared:
8/14/2019 12:00 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		24,207,016		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-5,642,905				2.00
3.00	Total (sum of line 1 and line 2)		18,564,111		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00	GRANTS	0		0		18,784	6.00
7.00	DONATION	0		0		16,350	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)		18,564,111		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00	EQUITY TRANSFER	1,921,953		0		0	14.00
15.00	PURCHASES	0		0		28,108	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)		1,921,953		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		16,642,158		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	10,040		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)	10,040		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00	GRANTS		0				6.00
7.00	DONATION		0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	35,134		0			10.00
11.00	Subtotal (line 3 plus line 10)	45,174		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00	EQUITY TRANSFER		0				14.00
15.00	PURCHASES		0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	28,108		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	17,066		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1334

Period:
From 04/01/2018
To 03/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
8/14/2019 12:00 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,904,429		1,904,429	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	1,337,625		1,337,625	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,242,054		3,242,054	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,242,054		3,242,054	17.00
18.00	Ancillary services	9,509,704	200,968,341	210,478,045	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	12,751,758	200,968,341	213,720,099	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		48,104,160		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		48,104,160		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1334

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

Worksheet G-3

Date/Time Prepared:
8/14/2019 12:00 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	213,720,099	1.00
2.00	Less contractual allowances and discounts on patients' accounts	141,521,380	2.00
3.00	Net patient revenues (line 1 minus line 2)	72,198,719	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	48,104,160	4.00
5.00	Net income from service to patients (line 3 minus line 4)	24,094,559	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	7,422	6.00
7.00	Income from investments	751,579	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	2,133	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	98,752	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	1,115	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	12,471	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	34,830	22.00
23.00	Governmental appropriations	22,360	23.00
24.00	OTHER (SPECIFY)	0	24.00
25.00	Total other income (sum of lines 6-24)	930,662	25.00
26.00	Total (line 5 plus line 25)	25,025,221	26.00
27.00	LOSS ON EQUIP, CORP ALLOC, CONTR	30,668,126	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	30,668,126	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-5,642,905	29.00