

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 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0011	Period: From 04/01/2019 To 03/31/2020	Worksheet S Parts I-III Date/Time Prepared: 8/28/2020 9:16 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 8/28/2020	Time: 9:16 am
	2. ☐ Manually prepared 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 HERRIN HOSPITAL (14-0011) for the cost reporting period beginning 04/01/2019 and ending 03/31/2020 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	1,234,361	-91,804	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	-24,448	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	1,209,913	-91,804	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: 14-0011		Period: From 04/01/2019 To 03/31/2020		Worksheet S-2 Part I Date/Time Prepared: 8/28/2020 9:15 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 201 S. 14TH STREET			PO Box:				1.00	
2.00	City: HERRIN			State: IL		Zip Code: 62948		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			HERRIN HOSPITAL	140011	16060	1	07/01/1966	N
4.00	Subprovider - IPF							P	0
5.00	Subprovider - IRF			HERRIN HOSPITAL ACUTE REHAB	14T011	16060	5	04/01/1998	N
6.00	Subprovider - (Other)							P	0
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						04/01/2019	03/31/2020	
21.00	Type of Control (see instructions)						2		
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			327	123	0	0	3,171	97

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet S-2
Part I
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		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	237	82	0	0	560		25.00
						Urban/Rural S	Date of Geogr	
						1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
						Beginning:	Ending:	
						1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					1		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					04/01/2019	03/31/2020	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
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals								
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		
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.							
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.							
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
				1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.					N		60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet S-2
Part I
Date/Time Prepared:
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	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00		2.00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
64.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		64.00

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

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			1.00	
Long Term Care Hospital PPS				
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00
TEFRA Providers				
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00
		V	XIX	
		1.00	2.00	
Title V and XIX Services				
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06
Rural Providers				
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00
		Physical	Occupational	Speech
		1.00	2.00	3.00
				Respiratory
				4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			
				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0011	Period: From 04/01/2019 To 03/31/2020	Worksheet S-2 Part I Date/Time Prepared: 8/28/2020 9:15 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
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		0115.00
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:	1,600,762	0	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	Y	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			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: 14-0011		Period: From 04/01/2019 To 03/31/2020		Worksheet S-2 Part I Date/Time Prepared: 8/28/2020 9:15 am		
1.00		2.00		3.00						
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.										
141.00	Name: SOUTHERN ILLINOIS HEALTHCARE		Contractor's Name: NGS		Contractor's Number: 06101				141.00	
142.00	Street: 1239 E. MAIN STREET		PO Box: 3988						142.00	
143.00	City: CARBONDALE		State: IL		Zip Code: 62901				143.00	
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?								Y	144.00
								1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				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			155.00
156.00	Subprovider - IPF			N	N	N	N			156.00
157.00	Subprovider - IRF			N	N	N	N			157.00
158.00	SUBPROVIDER									158.00
159.00	SNF			N	N	N	N			159.00
160.00	HOME HEALTH AGENCY			N	N	N	N			160.00
161.00	CMHC				N	N	N			161.00
								1.00		
Multicampus										
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus			
		0	1.00	2.00	3.00	4.00	5.00			
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00			166.00
								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)									168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								0.00	169.00
						Beginning	Ending			
						1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00	
						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: 14-0011	Period: From 04/01/2019 To 03/31/2020	Worksheet S-2 Part II Date/Time Prepared: 8/28/2020 9:15 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	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	07/22/2020	Y 07/22/2020
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: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet S-2
Part II
Date/Time Prepared:
8/28/2020 9:15 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		Y		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		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.	SOUTHERN ILLINOIS HEALTHCARE			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: 14-0011	Period: From 04/01/2019 To 03/31/2020	Worksheet S-2 Part II Date/Time Prepared: 8/28/2020 9:15 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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

Health Financial Systems		HERRIN HOSPITAL		Non-CMS HFS Worksheet	
HFS Supplemental Information		Provider CCN: 14-0011	Period: From 04/01/2019 To 03/31/2020	Worksheet S-2 Part IX Date/Time Prepared: 8/28/2020 9:15 am	
			Title V 1.00	Title XIX 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)	N	N	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)	N	N	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)	N	N	3.00	
3.01	Do Title V or XIX use W/S D-1 for reimbursement?	N	N	3.01	
			Inpatient 1.00	Outpatient 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 1.00	Title XIX 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)	N	N	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)	N	N	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	
			State 1.00		
STATE MEDICAID FORMS					
10.00	Select the state when using state Medicaid forms.			10.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet S-3
Part I
Date/Time Prepared:
8/28/2020 9:15 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	77	28,182	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		77	28,182	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,928	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		85	31,110	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	29	10,614		0	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)		114			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: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet S-3
Part I
Date/Time Prepared:
8/28/2020 9:15 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	12,392	408	20,771			1.00
2.00	HMO and other (see instructions)	2,031	3,268				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	604	560				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	12,392	408	20,771			7.00
8.00	INTENSIVE CARE UNIT	1,341	42	2,362			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)	13,733	450	23,133	0.00	750.23	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	4,980	319	7,788	0.00	60.88	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	811.11	27.00
28.00	Observation Bed Days		50	2,243			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: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet S-3
Part I
Date/Time Prepared:
8/28/2020 9:15 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	3,462	140	6,396	1.00
2.00 HMO and other (see instructions)			477	950		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				38		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	3,462	140	6,396	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	297	18	453	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet S-3
Part II
Date/Time Prepared:
8/28/2020 9:15 am

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	50,148,504	0	50,148,504	1,687,104.55	29.72
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		205,035	0	205,035	3,961.57	51.76
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		4,056,696	-199,940	3,856,756	127,191.61	30.32
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,042,768	0	1,042,768	15,242.15	68.41
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		76,919	0	76,919	385.00	199.79
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		8,977,317	0	8,977,317	238,165.92	37.69
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		9,246,730	0	9,246,730		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		773,810	0	773,810		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		41,138	0	41,138		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		3,698,702	0	3,698,702		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet S-3
Part II
Date/Time Prepared:
8/28/2020 9:15 am

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	118,836	0	118,836	3,538.59	33.58	26.00
27.00	Administrative & General	5.00	4,051,251	0	4,051,251	138,819.09	29.18	27.00
28.00	Administrative & General under contract (see inst.)		369,678	0	369,678	917.10	403.09	28.00
29.00	Maintenance & Repairs	6.00	617,339	0	617,339	24,288.73	25.42	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	50,860	0	50,860	3,115.05	16.33	31.00
32.00	Housekeeping	9.00	1,321,315	0	1,321,315	85,073.82	15.53	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,285,513	-856,786	428,727	24,316.58	17.63	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	856,786	856,786	48,596.69	17.63	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,017,770	0	1,017,770	28,575.51	35.62	38.00
39.00	Central Services and Supply	14.00	232,568	0	232,568	12,325.96	18.87	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	389,147	0	389,147	19,544.40	19.91	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet S-3
Part III
Date/Time Prepared:
8/28/2020 9:15 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	50,313,147	0	50,313,147	1,684,060.08	29.88	1.00
2.00	Excluded area salaries (see instructions)	4,056,696	-199,940	3,856,756	127,191.61	30.32	2.00
3.00	Subtotal salaries (line 1 minus line 2)	46,256,451	199,940	46,456,391	1,556,868.47	29.84	3.00
4.00	Subtotal other wages & related costs (see inst.)	10,097,004	0	10,097,004	253,793.07	39.78	4.00
5.00	Subtotal wage-related costs (see inst.)	12,945,432	0	12,945,432	0.00	27.87	5.00
6.00	Total (sum of lines 3 thru 5)	69,298,887	199,940	69,498,827	1,810,661.54	38.38	6.00
7.00	Total overhead cost (see instructions)	9,454,277	0	9,454,277	389,111.52	24.30	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet S-3
Part IV
Date/Time Prepared:
8/28/2020 9:15 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	863,421	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	4,414,087	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	75,492	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	35,381	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	120,599	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	199,939	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	621,436	16.00
TAXES			
17.00	FICA-Employers Portion Only	3,628,818	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	8,560	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	93,946	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	10,061,679	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet S-3
Part V
Date/Time Prepared:
8/28/2020 9:15 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	1,042,768	10,061,679	1.00
2.00	Hospital	1,042,768	10,061,679	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020

Worksheet S-10

Date/Time Prepared:
8/28/2020 9:15 am

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.194775	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		11,655,406	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		1,293,927	5.00
6.00	Medicaid charges		146,006,755	6.00
7.00	Medicaid cost (line 1 times line 6)		28,438,466	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)		15,489,133	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		1,332	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		15,489,133	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)	6,363,190	2,100,775	8,463,965
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,239,390	2,100,775	3,340,165
22.00	Payments received from patients for amounts previously written off as charity care	137	410	547
23.00	Cost of charity care (line 21 minus line 22)	1,239,253	2,100,365	3,339,618
			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)		11,505,751	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		1,242,991	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1,912,295	27.01
28.00	Non-Medicare bad debt expense (see instructions)		9,593,456	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		2,537,869	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		5,877,487	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		21,366,620	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020

Worksheet A

Date/Time Prepared:
8/28/2020 9:15 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		4,867,893	4,867,893	845,442	5,713,335	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,212,097	3,212,097	278,218	3,490,315	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	118,836	15,518,377	15,637,213	0	15,637,213	4.00
5.01	00550	DATA PROCESSING	0	0	0	0	0	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	251,566	35,130	286,696	0	286,696	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,164,615	45,986	1,210,601	0	1,210,601	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	2,635,070	8,192,264	10,827,334	-236	10,827,098	5.04
6.00	00600	MAINTENANCE & REPAIRS	617,339	1,180,469	1,797,808	0	1,797,808	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	50,860	681,779	732,639	0	732,639	8.00
9.00	00900	HOUSEKEEPING	1,321,315	384,862	1,706,177	0	1,706,177	9.00
10.00	01000	DIETARY	1,285,513	905,080	2,190,593	-1,460,016	730,577	10.00
11.00	01100	CAFETERIA	0	0	0	1,460,016	1,460,016	11.00
13.00	01300	NURSING ADMINISTRATION	1,017,770	93,884	1,111,654	0	1,111,654	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	232,568	53,994	286,562	-2,406	284,156	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	389,147	21,232	410,379	0	410,379	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	3,704,855	3,704,855	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,507,722	6,881,422	16,389,144	-32,974	16,356,170	30.00
31.00	03100	INTENSIVE CARE UNIT	1,966,418	614,392	2,580,810	-10,082	2,570,728	31.00
41.00	04100	SUBPROVIDER - IRF	3,842,390	1,543,255	5,385,645	-4,170	5,381,475	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,500,964	7,762,357	12,263,321	-3,571,874	8,691,447	50.00
51.00	05100	RECOVERY ROOM	814,342	7,843	822,185	0	822,185	51.00
53.00	05300	ANESTHESIOLOGY	524,909	3,982,027	4,506,936	-3,757,019	749,917	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,183,433	651,651	2,835,084	-26,620	2,808,464	54.00
56.00	05600	RADIOISOTOPE	212,227	982,609	1,194,836	-3,080	1,191,756	56.00
57.00	05700	CT SCAN	479,618	511,148	990,766	-67,170	923,596	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	330,913	447,716	778,629	-71,562	707,067	58.00
60.00	06000	LABORATORY	1,968,336	4,818,519	6,786,855	391,576	7,178,431	60.00
65.00	06500	RESPIRATORY THERAPY	1,256,514	273,198	1,529,712	-88,043	1,441,669	65.00
66.00	06600	PHYSICAL THERAPY	5,940,673	1,727,384	7,668,057	0	7,668,057	66.00
69.00	06900	ELECTROCARDIOLOGY	1,260,337	762,063	2,022,400	-339,568	1,682,832	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,812,868	3,812,868	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,317,625	6,317,625	0	6,317,625	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,207,122	6,251,937	8,459,059	491,332	8,950,391	73.00
76.97	07697	CARDIAC REHABILITATION	403,804	22,470	426,274	-275	425,999	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	254,693	318,903	573,596	-4,912	568,684	90.00
91.00	09100	EMERGENCY	3,195,184	6,020,381	9,215,565	-24,834	9,190,731	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		1,822,376	1,822,376	-1,123,660	698,716	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	49,934,198	86,912,323	136,846,521	395,806	137,242,327	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	3,014	290,331	293,345	0	293,345	192.00
192.01	19201	OUTREACH LAB	199,940	195,866	395,806	-395,806	0	192.01
192.02	19202	THERAPY CASH BASED SERVICES	11,352	4,783	16,135	0	16,135	192.02
200.00		TOTAL (SUM OF LINES 118 through 199)	50,148,504	87,403,303	137,551,807	0	137,551,807	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020

Worksheet A

Date/Time Prepared:
8/28/2020 9:15 am

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	-145,236	5,568,099	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,648,708	6,139,023	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-302,925	15,334,288	4.00
5.01	00550	DATA PROCESSING	8,615,804	8,615,804	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	-4,446	282,250	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,335,618	3,546,219	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	1,190,005	12,017,103	5.04
6.00	00600	MAINTENANCE & REPAIRS	-25,169	1,772,639	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	732,639	8.00
9.00	00900	HOUSEKEEPING	0	1,706,177	9.00
10.00	01000	DIETARY	0	730,577	10.00
11.00	01100	CAFETERIA	-648,835	811,181	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,111,654	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	284,156	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-51,790	358,589	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-3,704,855	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-3,719,086	12,637,084	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,570,728	31.00
41.00	04100	SUBPROVIDER - IRF	-1,698,423	3,683,052	41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-52,527	8,638,920	50.00
51.00	05100	RECOVERY ROOM	0	822,185	51.00
53.00	05300	ANESTHESIOLOGY	0	749,917	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-65,849	2,742,615	54.00
56.00	05600	RADIOISOTOPE	0	1,191,756	56.00
57.00	05700	CT SCAN	0	923,596	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	707,067	58.00
60.00	06000	LABORATORY	-292,415	6,886,016	60.00
65.00	06500	RESPIRATORY THERAPY	-945	1,440,724	65.00
66.00	06600	PHYSICAL THERAPY	-103,669	7,564,388	66.00
69.00	06900	ELECTROCARDIOLOGY	-80,150	1,602,682	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,812,868	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,317,625	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-490	8,949,901	73.00
76.97	07697	CARDIAC REHABILITATION	-1,253	424,746	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-1,582	567,102	90.00
91.00	09100	EMERGENCY	-4,399,748	4,790,983	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-698,716	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,207,974	136,034,353	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-89,602	203,743	192.00
192.01	19201	OUTREACH LAB	0	0	192.01
192.02	19202	THERAPY CASH BASED SERVICES	-4,920	11,215	192.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,302,496	136,249,311	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet Non-CMS W
Date/Time Prepared:
8/28/2020 9:15 am

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
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
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
31.00	INTENSIVE CARE UNIT	03100		31.00
41.00	SUBPROVIDER - IRF	04100		41.00
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
56.00	RADIOISOTOPE	05600		56.00
57.00	CT SCAN	05700		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
69.00	ELECTROCARDIOLOGY	06900		69.00
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	CARDIAC REHABILITATION	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	OUTREACH LAB	19201		192.01
192.02	THERAPY CASH BASED SERVICES	19202		192.02
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

RECLASSIFICATIONS

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020

Worksheet A-6

Date/Time Prepared:
8/28/2020 9:15 am

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - DEFAULT					
1.00	CAFETERIA	11.00	856,786	603,230	1.00
	TOTALS		856,786	603,230	
B - MEDICAL SUPPLY RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,812,868	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
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
	TOTALS		0	3,812,868	
C - CRNA RECLASS					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	3,704,855	1.00
	TOTALS		0	3,704,855	
D - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	845,442	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	278,218	2.00
	TOTALS		0	1,123,660	
E - CONTRAST DRUG RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	491,332	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
	TOTALS		0	491,332	
F - OUTREACH LAB RECLASS					
1.00	LABORATORY	60.00	199,940	195,866	1.00
	TOTALS		199,940	195,866	
500.00	Grand Total: Increases		1,056,726	9,931,811	500.00

RECLASSIFICATIONS

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020

Worksheet A-6

Date/Time Prepared:
8/28/2020 9:15 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DEFAULT						
1.00	DIETARY	10.00	856,786	603,230	0		1.00
	TOTALS		856,786	603,230			
	B - MEDICAL SUPPLY RECLASS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	236	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	32,974	0		2.00
3.00	SUBPROVIDER - IRF	41.00	0	4,170	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	10,082	0		4.00
5.00	OPERATING ROOM	50.00	0	3,564,223	0		5.00
6.00	RADIOISOTOPE	56.00	0	3,080	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,406	0		7.00
8.00	EMERGENCY	91.00	0	24,834	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	52,164	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	12,321	0		10.00
11.00	CT SCAN	57.00	0	7,910	0		11.00
12.00	LABORATORY	60.00	0	4,230	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	88,043	0		13.00
14.00	CARDIAC REHABILITATION	76.97	0	275	0		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	1,008	0		15.00
16.00	CLINIC	90.00	0	4,912	0		16.00
	TOTALS		0	3,812,868			
	C - CRNA RECLASS						
1.00	ANESTHESIOLOGY	53.00	0	3,704,855	0		1.00
	TOTALS		0	3,704,855			
	D - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	1,123,660	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	1,123,660			
	E - CONTRAST DRUG RECLASS						
1.00	ELECTROCARDIOLOGY	69.00	0	338,560	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	14,299	0		2.00
3.00	CT SCAN	57.00	0	59,260	0		3.00
4.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	71,562	0		4.00
5.00	OPERATING ROOM	50.00	0	7,651	0		5.00
	TOTALS		0	491,332			
	F - OUTREACH LAB RECLASS						
1.00	OUTREACH LAB	192.01	199,940	195,866	0		1.00
	TOTALS		199,940	195,866			
500.00	Grand Total: Decreases		1,056,726	9,931,811			500.00

RECLASSIFICATIONS

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
8/28/2020 9:15 am

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 - DEFAULT									
1.00	CAFETERIA	11.00	856,786	603,230	DIETARY	10.00	856,786	603,230	1.00
	TOTALS		856,786	603,230	TOTALS		856,786	603,230	
B - MEDICAL SUPPLY RECLASS									
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,812,868	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	236	1.00
2.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	32,974	2.00
3.00		0.00	0	0	SUBPROVIDER - IRF	41.00	0	4,170	3.00
4.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	10,082	4.00
5.00		0.00	0	0	OPERATING ROOM	50.00	0	3,564,223	5.00
6.00		0.00	0	0	RADIOISOTOPE	56.00	0	3,080	6.00
7.00		0.00	0	0	CENTRAL SERVICES & SUPPLY	14.00	0	2,406	7.00
8.00		0.00	0	0	EMERGENCY	91.00	0	24,834	8.00
9.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	52,164	9.00
10.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	12,321	10.00
11.00		0.00	0	0	CT SCAN	57.00	0	7,910	11.00
12.00		0.00	0	0	LABORATORY	60.00	0	4,230	12.00
13.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	88,043	13.00
14.00		0.00	0	0	CARDIAC REHABILITATION	76.97	0	275	14.00
15.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	1,008	15.00
16.00		0.00	0	0	CLINIC	90.00	0	4,912	16.00
	TOTALS		0	3,812,868	TOTALS		0	3,812,868	
C - CRNA RECLASS									
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	3,704,855	ANESTHESIOLOGY	53.00	0	3,704,855	1.00
	TOTALS		0	3,704,855	TOTALS		0	3,704,855	
D - INTEREST RECLASS									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	845,442	INTEREST EXPENSE	113.00	0	1,123,660	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	278,218		0.00	0	0	2.00
	TOTALS		0	1,123,660	TOTALS		0	1,123,660	
E - CONTRAST DRUG RECLASS									
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	491,332	ELECTROCARDIOLOGY	69.00	0	338,560	1.00
2.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	14,299	2.00
3.00		0.00	0	0	CT SCAN	57.00	0	59,260	3.00
4.00		0.00	0	0	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	71,562	4.00
5.00		0.00	0	0	OPERATING ROOM	50.00	0	7,651	5.00
	TOTALS		0	491,332	TOTALS		0	491,332	
F - OUTREACH LAB RECLASS									
1.00	LABORATORY	60.00	199,940	195,866	OUTREACH LAB	192.01	199,940	195,866	1.00
	TOTALS		199,940	195,866	TOTALS		199,940	195,866	
500.00	Grand Total: Increases		1,056,726	9,931,811	Grand Total: Decreases		1,056,726	9,931,811	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet A-7
Part I
Date/Time Prepared:
8/28/2020 9:15 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	4,989,120	81,163	0	81,163	0	1.00	
2.00	Land Improvements	5,766,536	137,349	0	137,349	7,076	2.00	
3.00	Buildings and Fixtures	95,511,925	1,282,506	0	1,282,506	553,028	3.00	
4.00	Building Improvements	26,804	8,745	0	8,745	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	35,232,521	4,225,309	0	4,225,309	2,257,418	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	141,526,906	5,735,072	0	5,735,072	2,817,522	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	141,526,906	5,735,072	0	5,735,072	2,817,522	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	5,070,283	0				1.00	
2.00	Land Improvements	5,896,809	0				2.00	
3.00	Buildings and Fixtures	96,241,403	0				3.00	
4.00	Building Improvements	35,549	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	37,200,412	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	144,444,456	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	144,444,456	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet A-7
Part II
Date/Time Prepared:
8/28/2020 9:15 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	4,867,893	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,212,097	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	8,079,990	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	4,867,893				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,212,097				2.00
3.00	Total (sum of lines 1-2)	0	8,079,990				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet A-7
Part III
Date/Time Prepared:
8/28/2020 9:15 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
		1.00	2.00	3.00	4.00	5.00		
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	107,244,044	0	107,244,044	0.742459	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	37,200,412	0	37,200,412	0.257541	0	2.00	
3.00	Total (sum of lines 1-2)	144,444,456	0	144,444,456	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	5,568,099	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	6,139,023	0	2.00	
3.00	Total (sum of lines 1-2)	0	0	0	11,707,122	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	5,568,099	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	6,139,023	2.00	
3.00	Total (sum of lines 1-2)	0	0	0	0	11,707,122	3.00	

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020

Worksheet A-8

Date/Time Prepared:
8/28/2020 9:15 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
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	-10,138,887			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	26,459,242			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-648,835	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-51,790	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			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-3,704,855	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)			0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	CABLE TV	A	-25,169	MAINTENANCE & REPAIRS	6.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020

Worksheet A-8

Date/Time Prepared:
8/28/2020 9:15 am

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33.01 INTEREST INCOME UNRESTRICTED	B	-721,511	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.01
33.02 PAYMENTS FOR OUTPATIENT SERVICES	B	-5,442,846	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.02
33.03 NONALLOWABLE BOND EXPENSE	A	-698,716	INTEREST EXPENSE	113.00	0	33.03
33.04 PURCHASE DISCOUNTS	B	-4,446	PURCHASING RECEIVING AND STORES	5.02	0	33.04
33.05 CABLE TV	A	-1,235	SUBPROVIDER - IRF	41.00	0	33.05
33.06 OFFSET LOBBYING EXPENSE	A	-18,337	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.06
33.07 COMMUNITY DONATIONS	A	-93	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.07
33.08 LEASEHOLD REVENUE	B	-541,014	CAP REL COSTS-BLDG & FIXT	1.00	9	33.08
33.09 DEBT FORGIVENESS	A	-73,385	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.09
33.10 REAL ESTATE TAXES	A	-37,678	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.10
33.11 MEDICAID PROVIDER TAX	A	-5,632,809	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.11
33.12 MISCELLANEOUS INCOME	B	-49	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.12
33.13 CABLE TV	A	-98	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.13
33.14 MISCELLANEOUS INCOME	B	1,173	ADULTS & PEDIATRICS	30.00	0	33.14
33.15 XRAY FILM	B	-1,494	RADIOLOGY-DIAGNOSTIC	54.00	0	33.15
33.16 EKG DEPARTMENTAL PROGRAM REVENUE	B	-1,500	ELECTROCARDIOLOGY	69.00	0	33.16
33.17 IRF PHO INCENTIVE	B	-4,751	SUBPROVIDER - IRF	41.00	0	33.17
33.18 LOSS ON 1991 BONDS	A	39,030	CAP REL COSTS-BLDG & FIXT	1.00	9	33.18
33.19 LOSS ON 1991 BONDS	A	53,546	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.19
33.20 CABLE TV	A	-892	CLINIC	90.00	0	33.20
33.21 REAL ESTATE TAXES	A	-89,602	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.21
33.22 REAL ESTATE TAXES	A	-9,609	PHYSICAL THERAPY	66.00	0	33.22
33.23 CABLE TV	A	-263	PHYSICAL THERAPY	66.00	0	33.23
33.24 MISCELLANEOUS INCOME	B	-490	DRUGS CHARGED TO PATIENTS	73.00	0	33.24
33.25 ALCOHOL PURCHASE	A	-20	OPERATING ROOM	50.00	0	33.25
33.26 ALCOHOL PURCHASE	A	-9	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.26
33.27 ALCOHOL PURCHASE	A	-62	PHYSICAL THERAPY	66.00	0	33.27
33.28 DEPARTMENTAL REVENUE	B	-4,920	THERAPY CASH BASED SERVICES	192.02	0	33.28
33.29 RIDES FOR PATIENTS	A	-122	ADULTS & PEDIATRICS	30.00	0	33.29
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,302,496				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: 14-0011

Period:
From 04/01/2019
To 03/31/2020

Worksheet A-8-1

Date/Time Prepared:
8/28/2020 9:15 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	356,748	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	2,595,162	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	5,139,921	0	3.00
4.00	5.01	DATA PROCESSING	HOME OFFICE	8,615,804	0	4.00
4.01	5.03	CASHIERING/ACCOUNTS RECEIVAB	HOME OFFICE	2,335,618	0	4.01
4.02	5.04	OTHER ADMINISTRATIVE AND GEN	HOME OFFICE	7,691,440	0	4.02
4.03	60.00	LABORATORY	RENT	35,036	73,747	4.03
4.04	54.00	RADIOLOGY-DIAGNOSTIC	RENT	49,345	113,700	4.04
4.05	66.00	PHYSICAL THERAPY	RENT	69,963	163,698	4.05
4.06	69.00	ELECTROCARDIOLOGY	RENT	79,174	157,824	4.06
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			26,968,211	508,969	5.00

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

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			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	100.00	6.00
7.00	B	SIHE	100.00	100.00	7.00
8.00	B	HSSI	100.00	100.00	8.00
9.00	B	SIMS	100.00	100.00	9.00
10.00	B	SIH CAYMAN	100.00	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: 14-0011

Period:
From 04/01/2019
To 03/31/2020

Worksheet A-8-1

Date/Time Prepared:
8/28/2020 9:15 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	356,748	9		1.00
2.00	2,595,162	9		2.00
3.00	5,139,921	0		3.00
4.00	8,615,804	0		4.00
4.01	2,335,618	0		4.01
4.02	7,691,440	0		4.02
4.03	-38,711	0		4.03
4.04	-64,355	0		4.04
4.05	-93,735	0		4.05
4.06	-78,650	0		4.06
5.00	26,459,242			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			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020

Worksheet A-8-2

Date/Time Prepared:
8/28/2020 9:15 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	DR. A	253,704	253,704	0	0	0	1.00
2.00	65.00	DR. B	1,806	0	1,806	179,000	10	2.00
3.00	76.97	DR. C	2,200	0	2,200	179,000	11	3.00
4.00	91.00	DR. D	4,405,065	4,396,647	8,418	181,300	61	4.00
5.00	30.00	DR. E	3,713,275	3,713,275	0	0	0	5.00
6.00	41.00	DR. F	1,692,437	1,692,437	0	0	0	6.00
7.00	50.00	DR. G	83,070	30,000	53,070	246,400	258	7.00
8.00	30.00	DR. H	9,100	0	9,100	179,000	26	8.00
9.00	90.00	DR. I	2,325	0	2,325	179,000	19	9.00
10.00	5.04	DR. J	17,466	17,466	0	0	0	10.00
200.00			10,180,448	10,103,529	76,919		385	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	60.00	DR. A	0	0	0	0	0	1.00
2.00	65.00	DR. B	861	43	0	0	0	2.00
3.00	76.97	DR. C	947	47	0	0	0	3.00
4.00	91.00	DR. D	5,317	266	0	0	0	4.00
5.00	30.00	DR. E	0	0	0	0	0	5.00
6.00	41.00	DR. F	0	0	0	0	0	6.00
7.00	50.00	DR. G	30,563	1,528	0	0	0	7.00
8.00	30.00	DR. H	2,238	112	0	0	0	8.00
9.00	90.00	DR. I	1,635	82	0	0	0	9.00
10.00	5.04	DR. J	0	0	0	0	0	10.00
200.00			41,561	2,078	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	60.00	DR. A	0	0	0	253,704		1.00
2.00	65.00	DR. B	0	861	945	945		2.00
3.00	76.97	DR. C	0	947	1,253	1,253		3.00
4.00	91.00	DR. D	0	5,317	3,101	4,399,748		4.00
5.00	30.00	DR. E	0	0	0	3,713,275		5.00
6.00	41.00	DR. F	0	0	0	1,692,437		6.00
7.00	50.00	DR. G	0	30,563	22,507	52,507		7.00
8.00	30.00	DR. H	0	2,238	6,862	6,862		8.00
9.00	90.00	DR. I	0	1,635	690	690		9.00
10.00	5.04	DR. J	0	0	0	17,466		10.00
200.00			0	41,561	35,358	10,138,887		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet B
Part I
Date/Time Prepared:
8/28/2020 9:15 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	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	5,568,099	5,568,099			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	6,139,023		6,139,023		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	15,334,288	40,425	4,811	15,379,524	4.00
5.01	00550	DATA PROCESSING	8,615,804	25,687	0	0	8,641,491
5.02	00560	PURCHASING RECEIVING AND STORES	282,250	45,899	281	77,333	64,974
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	3,546,219	41,119	4,600	358,012	287,740
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	12,017,103	1,021,425	55,855	810,042	556,917
6.00	00600	MAINTENANCE & REPAIRS	1,772,639	701,567	10,741	189,775	176,357
8.00	00800	LAUNDRY & LINEN SERVICE	732,639	0	604	15,635	9,282
9.00	00900	HOUSEKEEPING	1,706,177	76,416	33,483	406,183	27,846
10.00	01000	DIETARY	730,577	85,953	22,719	131,794	92,819
11.00	01100	CAFETERIA	811,181	102,673	0	263,383	0
13.00	01300	NURSING ADMINISTRATION	1,111,654	27,371	700,888	312,871	37,128
14.00	01400	CENTRAL SERVICES & SUPPLY	284,156	72,205	15,188	71,493	9,282
16.00	01600	MEDICAL RECORDS & LIBRARY	358,589	0	0	119,627	194,921
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,637,084	930,246	215,733	2,922,754	1,420,137
31.00	03100	INTENSIVE CARE UNIT	2,570,728	111,615	95,119	604,493	167,075
41.00	04100	SUBPROVIDER - IRF	3,683,052	427,831	89,816	1,181,181	798,247
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,638,920	675,979	2,598,644	1,383,632	1,243,781
51.00	05100	RECOVERY ROOM	822,185	104,060	8,715	250,335	120,665
53.00	05300	ANESTHESIOLOGY	749,917	694	62,612	161,361	92,819
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,742,615	169,156	844,961	671,205	361,996
56.00	05600	RADIOISOTOPE	1,191,756	35,570	5,372	65,240	64,974
57.00	05700	CT SCAN	923,596	25,266	351,899	147,438	27,846
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	707,067	18,107	306,108	101,725	27,846
60.00	06000	LABORATORY	6,886,016	140,125	238,369	666,545	473,379
65.00	06500	RESPIRATORY THERAPY	1,440,724	64,006	94,665	386,262	232,049
66.00	06600	PHYSICAL THERAPY	7,564,388	193,158	55,544	1,826,210	1,076,706
69.00	06900	ELECTROCARDIOLOGY	1,602,682	66,954	64,467	387,438	334,150
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,812,868	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,317,625	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	8,949,901	47,039	51,607	678,487	157,793
76.97	07697	CARDIAC REHABILITATION	424,746	46,518	18,223	124,133	111,383
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	567,102	0	30,096	78,295	92,819
91.00	09100	EMERGENCY	4,790,983	249,733	134,030	982,225	371,278
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	136,034,353	5,546,797	6,115,150	15,375,107	8,632,209
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	21,302	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	203,743	0	23,873	927	9,282
192.01	19201	OUTREACH LAB	0	0	0	0	0
192.02	19202	THERAPY CASH BASED SERVICES	11,215	0	0	3,490	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		TOTAL (sum lines 118 through 201)	136,249,311	5,568,099	6,139,023	15,379,524	8,641,491

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet B
Part I
Date/Time Prepared:
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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	470,737					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,550	4,239,240				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	2	0	14,461,344	14,461,344		5.04
6.00	00600	MAINTENANCE & REPAIRS	9	0	2,851,088	338,544	3,189,632	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	758,160	90,025	0	8.00
9.00	00900	HOUSEKEEPING	0	0	2,250,105	267,182	66,019	9.00
10.00	01000	DIETARY	0	0	1,063,862	126,325	74,258	10.00
11.00	01100	CAFETERIA	0	0	1,177,237	139,787	88,703	11.00
13.00	01300	NURSING ADMINISTRATION	87	0	2,189,999	260,045	23,647	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	333	0	452,657	53,749	62,381	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	673,137	79,930	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	100,449	171,748	18,398,151	2,184,630	803,672	30.00
31.00	03100	INTENSIVE CARE UNIT	27,055	23,077	3,599,162	427,372	96,428	31.00
41.00	04100	SUBPROVIDER - IRF	14,267	93,381	6,287,775	746,623	369,619	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	203,091	741,688	15,485,735	1,838,807	584,003	50.00
51.00	05100	RECOVERY ROOM	168	54,457	1,360,585	161,559	89,901	51.00
53.00	05300	ANESTHESIOLOGY	9,527	110,894	1,187,824	141,045	599	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,943	241,922	5,034,798	597,842	146,140	54.00
56.00	05600	RADIOISOTOPE	624	99,007	1,462,543	173,665	30,730	56.00
57.00	05700	CT SCAN	8,656	512,594	1,997,295	237,163	21,828	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	585	149,580	1,311,018	155,673	15,643	58.00
60.00	06000	LABORATORY	22,274	685,500	9,112,208	1,082,002	121,059	60.00
65.00	06500	RESPIRATORY THERAPY	7,878	64,689	2,290,273	271,952	55,297	65.00
66.00	06600	PHYSICAL THERAPY	1,765	277,237	10,995,008	1,305,569	166,876	66.00
69.00	06900	ELECTROCARDIOLOGY	2,183	182,861	2,640,735	313,566	57,844	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	124,524	3,937,392	467,534	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	128,304	6,445,929	765,403	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,077	240,458	10,126,362	1,202,424	40,638	73.00
76.97	07697	CARDIAC REHABILITATION	96	15,718	740,817	87,966	40,189	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,967	41,698	811,977	96,416	0	90.00
91.00	09100	EMERGENCY	64,149	279,903	6,872,301	816,031	215,754	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)	470,735	4,239,240	135,975,477	14,428,829	3,171,228	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	21,302	2,529	18,404	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2	0	237,827	28,240	0	192.00
192.01	19201	OUTREACH LAB	0	0	0	0	0	192.01
192.02	19202	THERAPY CASH BASED SERVICES	0	0	14,705	1,746	0	192.02
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)	470,737	4,239,240	136,249,311	14,461,344	3,189,632	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet B
Part I
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Cost Center Description			LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	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
8.00	00800	LAUNDRY & LINEN SERVICE	848,185					8.00
9.00	00900	HOUSEKEEPING	0	2,583,306				9.00
10.00	01000	DIETARY	0	61,413	1,325,858			10.00
11.00	01100	CAFETERIA	0	73,359	0	1,479,086		11.00
13.00	01300	NURSING ADMINISTRATION	0	19,557	0	35,251	2,528,499	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	51,590	0	8,055	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	13,478	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	554,630	664,659	890,637	329,322	1,040,506	30.00
31.00	03100	INTENSIVE CARE UNIT	68,313	79,748	101,280	68,109	160,888	31.00
41.00	04100	SUBPROVIDER - IRF	225,242	305,684	333,941	133,085	436,256	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	482,985	0	155,895	478,732	50.00
51.00	05100	RECOVERY ROOM	0	74,350	0	28,206	60,872	51.00
53.00	05300	ANESTHESIOLOGY	0	496	0	18,181	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	120,861	0	75,625	0	54.00
56.00	05600	RADIOISOTOPE	0	25,415	0	7,351	0	56.00
57.00	05700	CT SCAN	0	18,052	0	16,612	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	12,937	0	11,462	0	58.00
60.00	06000	LABORATORY	0	100,119	0	75,100	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	45,732	0	43,521	0	65.00
66.00	06600	PHYSICAL THERAPY	0	138,011	0	205,761	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	47,838	0	43,653	0	69.00
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	33,609	0	76,446	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	33,237	0	13,986	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	8,822	0	90.00
91.00	09100	EMERGENCY	0	178,434	0	110,668	351,245	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	848,185	2,568,086	1,325,858	1,478,589	2,528,499	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,220	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	104	0	192.00
192.01	19201	OUTREACH LAB	0	0	0	0	0	192.01
192.02	19202	THERAPY CASH BASED SERVICES	0	0	0	393	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	848,185	2,583,306	1,325,858	1,479,086	2,528,499	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet B
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Cost Center Description			CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	16.00	19.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	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
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	628,432					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	766,545				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,879	31,052	0	24,902,138	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,492	4,172	0	4,606,964	0	31.00
41.00	04100	SUBPROVIDER - IRF	617	16,883	0	8,855,725	0	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	527,332	134,194	0	19,687,683	0	50.00
51.00	05100	RECOVERY ROOM	0	9,846	0	1,785,319	0	51.00
53.00	05300	ANESTHESIOLOGY	7,718	20,049	0	1,375,912	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,823	43,739	0	6,020,828	0	54.00
56.00	05600	RADIOISOTOPE	456	17,900	0	1,718,060	0	56.00
57.00	05700	CT SCAN	1,170	92,676	0	2,384,796	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	27,044	0	1,533,777	0	58.00
60.00	06000	LABORATORY	64,972	123,937	0	10,679,397	0	60.00
65.00	06500	RESPIRATORY THERAPY	13,026	11,696	0	2,731,497	0	65.00
66.00	06600	PHYSICAL THERAPY	0	50,124	0	12,861,349	0	66.00
69.00	06900	ELECTROCARDIOLOGY	149	33,061	0	3,136,846	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	356	22,514	0	4,427,796	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	23,197	0	7,234,529	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	43,474	0	11,522,953	0	73.00
76.97	07697	CARDIAC REHABILITATION	41	2,842	0	919,078	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	727	7,539	0	925,481	0	90.00
91.00	09100	EMERGENCY	3,674	50,606	0	8,598,713	0	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)	628,432	766,545	0	135,908,841	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	57,455	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	266,171	0	192.00
192.01	19201	OUTREACH LAB	0	0	0	0	0	192.01
192.02	19202	THERAPY CASH BASED SERVICES	0	0	0	16,844	0	192.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	628,432	766,545	0	136,249,311	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet B
Part I
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	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
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
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	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
41.00	04100	SUBPROVIDER - IRF	41.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.97	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	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)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	OUTREACH LAB	192.01
192.02	19202	THERAPY CASH BASED SERVICES	192.02
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION STATISTICS

Provider CCN: 14-0011

Period:

From 04/01/2019

To 03/31/2020

Worksheet Non-CMS W

Date/Time Prepared:
8/28/2020 9:15 am

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	2	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4	GROSS SALARIES	4.00
5.01	DATA PROCESSING	5	NUMBER OF PCS	5.01
5.02	PURCHASING RECEIVING AND STORES	6	PURCHASING SUPPLIES	5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE	7	GROSS REVENUE	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	-5	ACCUM. COST	5.04
6.00	MAINTENANCE & REPAIRS	1	SQUARE FEET	6.00
8.00	LAUNDRY & LINEN SERVICE	8	PATIENT DAYS	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	10	MEALS SERVED	10.00
11.00	CAFETERIA	4	GROSS SALARIES	11.00
13.00	NURSING ADMINISTRATION	3	NURSING HOURS	13.00
14.00	CENTRAL SERVICES & SUPPLY	11	COSTED REQUIS.	14.00
16.00	MEDICAL RECORDS & LIBRARY	7	GROSS REVENUE	16.00
19.00	NONPHYSICIAN ANESTHETISTS	12	ASSIGNED TIME	19.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet B
Part II
Date/Time Prepared:
8/28/2020 9:15 am

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	40,425	4,811	45,236	4.00
5.01	00550	DATA PROCESSING	0	25,687	0	25,687	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	45,899	281	46,180	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	41,119	4,600	45,719	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	1,021,425	55,855	1,077,280	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	701,567	10,741	712,308	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	604	604	8.00
9.00	00900	HOUSEKEEPING	0	76,416	33,483	109,899	9.00
10.00	01000	DIETARY	0	85,953	22,719	108,672	10.00
11.00	01100	CAFETERIA	0	102,673	0	102,673	11.00
13.00	01300	NURSING ADMINISTRATION	0	27,371	700,888	728,259	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	72,205	15,188	87,393	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	930,246	215,733	1,145,979	30.00
31.00	03100	INTENSIVE CARE UNIT	0	111,615	95,119	206,734	31.00
41.00	04100	SUBPROVIDER - IRF	0	427,831	89,816	517,647	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	675,979	2,598,644	3,274,623	50.00
51.00	05100	RECOVERY ROOM	0	104,060	8,715	112,775	51.00
53.00	05300	ANESTHESIOLOGY	0	694	62,612	63,306	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	169,156	844,961	1,014,117	54.00
56.00	05600	RADIOISOTOPE	0	35,570	5,372	40,942	56.00
57.00	05700	CT SCAN	0	25,266	351,899	377,165	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	18,107	306,108	324,215	58.00
60.00	06000	LABORATORY	0	140,125	238,369	378,494	60.00
65.00	06500	RESPIRATORY THERAPY	0	64,006	94,665	158,671	65.00
66.00	06600	PHYSICAL THERAPY	0	193,158	55,544	248,702	66.00
69.00	06900	ELECTROCARDIOLOGY	0	66,954	64,467	131,421	69.00
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	47,039	51,607	98,646	73.00
76.97	07697	CARDIAC REHABILITATION	0	46,518	18,223	64,741	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	30,096	30,096	90.00
91.00	09100	EMERGENCY	0	249,733	134,030	383,763	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,546,797	6,115,150	11,661,947	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	21,302	0	21,302	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	23,873	23,873	192.00
192.01	19201	OUTREACH LAB	0	0	0	0	192.01
192.02	19202	THERAPY CASH BASED SERVICES	0	0	0	0	192.02
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	5,568,099	6,139,023	11,707,122	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet B
Part II
Date/Time Prepared:
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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	25,687					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	193	46,600				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	855	153	47,780			5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	1,655	0	0	1,081,317		5.04
6.00	00600	MAINTENANCE & REPAIRS	524	1	0	25,315	738,706	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	28	0	0	6,732	0	8.00
9.00	00900	HOUSEKEEPING	83	0	0	19,979	15,290	9.00
10.00	01000	DIETARY	276	0	0	9,446	17,198	10.00
11.00	01100	CAFETERIA	0	0	0	10,453	20,543	11.00
13.00	01300	NURSING ADMINISTRATION	110	9	0	19,445	5,477	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	28	33	0	4,019	14,447	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	579	0	0	5,977	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	4,220	9,943	1,928	163,316	186,126	30.00
31.00	03100	INTENSIVE CARE UNIT	497	2,678	259	31,957	22,332	31.00
41.00	04100	SUBPROVIDER - IRF	2,373	1,412	1,048	55,829	85,602	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,697	20,106	8,516	137,498	135,253	50.00
51.00	05100	RECOVERY ROOM	359	17	611	12,081	20,821	51.00
53.00	05300	ANESTHESIOLOGY	276	943	1,245	10,547	139	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,076	291	2,716	44,704	33,845	54.00
56.00	05600	RADIOISOTOPE	193	62	1,112	12,986	7,117	56.00
57.00	05700	CT SCAN	83	857	5,755	17,734	5,055	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	83	58	1,679	11,641	3,623	58.00
60.00	06000	LABORATORY	1,407	2,205	7,696	80,907	28,037	60.00
65.00	06500	RESPIRATORY THERAPY	690	780	726	20,335	12,807	65.00
66.00	06600	PHYSICAL THERAPY	3,201	175	3,112	97,625	38,648	66.00
69.00	06900	ELECTROCARDIOLOGY	993	216	2,053	23,447	13,396	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,398	34,960	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,440	57,233	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	469	107	2,700	89,912	9,412	73.00
76.97	07697	CARDIAC REHABILITATION	331	9	176	6,578	9,308	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	276	195	468	7,210	0	90.00
91.00	09100	EMERGENCY	1,104	6,350	3,142	61,019	49,968	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)	25,659	46,600	47,780	1,078,885	734,444	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	189	4,262	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	28	0	0	2,112	0	192.00
192.01	19201	OUTREACH LAB	0	0	0	0	0	192.01
192.02	19202	THERAPY CASH BASED SERVICES	0	0	0	131	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	25,687	46,600	47,780	1,081,317	738,706	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0011

Period:
From 04/01/2019
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Cost Center Description			LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	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
8.00	00800	LAUNDRY & LINEN SERVICE	7,410					8.00
9.00	00900	HOUSEKEEPING	0	146,445				9.00
10.00	01000	DIETARY	0	3,481	139,461			10.00
11.00	01100	CAFETERIA	0	4,159	0	138,603		11.00
13.00	01300	NURSING ADMINISTRATION	0	1,109	0	3,304	758,633	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,925	0	755	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,263	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	4,845	37,677	93,682	30,850	312,186	30.00
31.00	03100	INTENSIVE CARE UNIT	597	4,521	10,653	6,383	48,272	31.00
41.00	04100	SUBPROVIDER - IRF	1,968	17,329	35,126	12,472	130,891	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	27,380	0	14,610	143,635	50.00
51.00	05100	RECOVERY ROOM	0	4,215	0	2,643	18,264	51.00
53.00	05300	ANESTHESIOLOGY	0	28	0	1,704	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,852	0	7,087	0	54.00
56.00	05600	RADIOISOTOPE	0	1,441	0	689	0	56.00
57.00	05700	CT SCAN	0	1,023	0	1,557	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	733	0	1,074	0	58.00
60.00	06000	LABORATORY	0	5,676	0	7,038	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,593	0	4,079	0	65.00
66.00	06600	PHYSICAL THERAPY	0	7,824	0	19,283	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,712	0	4,091	0	69.00
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	1,905	0	7,164	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,884	0	1,311	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	827	0	90.00
91.00	09100	EMERGENCY	0	10,115	0	10,372	105,385	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)	7,410	145,582	139,461	138,556	758,633	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	863	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	10	0	192.00
192.01	19201	OUTREACH LAB	0	0	0	0	0	192.01
192.02	19202	THERAPY CASH BASED SERVICES	0	0	0	37	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,410	146,445	139,461	138,603	758,633	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0011

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Cost Center Description			CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	16.00	19.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	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
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	109,810					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,171				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	852	345		2,000,553	0	30.00
31.00	03100	INTENSIVE CARE UNIT	261	46		336,968	0	31.00
41.00	04100	SUBPROVIDER - IRF	108	188		865,467	0	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	92,144	1,140		3,862,671	0	50.00
51.00	05100	RECOVERY ROOM	0	109		172,631	0	51.00
53.00	05300	ANESTHESIOLOGY	1,349	223		80,235	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	319	486		1,113,467	0	54.00
56.00	05600	RADIOISOTOPE	80	199		65,013	0	56.00
57.00	05700	CT SCAN	204	1,031		410,898	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	301		343,706	0	58.00
60.00	06000	LABORATORY	11,353	1,378		526,151	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,276	130		204,223	0	65.00
66.00	06600	PHYSICAL THERAPY	0	557		424,497	0	66.00
69.00	06900	ELECTROCARDIOLOGY	26	368		179,862	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	62	250		36,670	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	258		58,931	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	483		212,793	0	73.00
76.97	07697	CARDIAC REHABILITATION	7	32		84,742	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	127	84		39,513	0	90.00
91.00	09100	EMERGENCY	642	563		635,311	0	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)	109,810	8,171	0	11,654,302	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		26,616	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		26,026	0	192.00
192.01	19201	OUTREACH LAB	0	0		0	0	192.01
192.02	19202	THERAPY CASH BASED SERVICES	0	0		178	0	192.02
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	109,810	8,171	0	11,707,122	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet B
Part II
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	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
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
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	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
41.00	04100	SUBPROVIDER - IRF	41.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.97	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	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)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	OUTREACH LAB	192.01
192.02	19202	THERAPY CASH BASED SERVICES	192.02
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020

Worksheet B-1

Date/Time Prepared:
8/28/2020 9:15 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (NUMBER OF PCS)	PURCHASING RECEIVING AND STORES (PURCHASING SUPPLIES)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	224,790				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,212,099			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,632	2,517	50,029,668		4.00
5.01	00550	DATA PROCESSING	1,037	0	0	931	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	1,853	147	251,566	7	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,660	2,407	1,164,615	31	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	41,236	29,225	2,635,070	60	5.04
6.00	00600	MAINTENANCE & REPAIRS	28,323	5,620	617,339	19	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	316	50,860	1	8.00
9.00	00900	HOUSEKEEPING	3,085	17,519	1,321,315	3	9.00
10.00	01000	DIETARY	3,470	11,887	428,727	10	10.00
11.00	01100	CAFETERIA	4,145	0	856,786	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,105	366,723	1,017,770	4	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,915	7,947	232,568	1	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	389,147	21	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	37,555	112,877	9,507,722	153	30.00
31.00	03100	INTENSIVE CARE UNIT	4,506	49,769	1,966,418	18	31.00
41.00	04100	SUBPROVIDER - IRF	17,272	46,994	3,842,390	86	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	27,290	1,359,679	4,500,964	134	50.00
51.00	05100	RECOVERY ROOM	4,201	4,560	814,342	13	51.00
53.00	05300	ANESTHESIOLOGY	28	32,760	524,909	10	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,829	442,106	2,183,433	39	54.00
56.00	05600	RADIOISOTOPE	1,436	2,811	212,227	7	56.00
57.00	05700	CT SCAN	1,020	184,123	479,618	3	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	731	160,164	330,913	3	58.00
60.00	06000	LABORATORY	5,657	124,721	2,168,276	51	60.00
65.00	06500	RESPIRATORY THERAPY	2,584	49,531	1,256,514	25	65.00
66.00	06600	PHYSICAL THERAPY	7,798	29,062	5,940,673	116	66.00
69.00	06900	ELECTROCARDIOLOGY	2,703	33,731	1,260,337	36	69.00
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	1,899	27,002	2,207,122	17	73.00
76.97	07697	CARDIAC REHABILITATION	1,878	9,535	403,804	12	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	15,747	254,693	10	90.00
91.00	09100	EMERGENCY	10,082	70,128	3,195,184	40	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)	223,930	3,199,608	50,015,302	930	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	860	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	12,491	3,014	1	192.00
192.01	19201	OUTREACH LAB	0	0	0	0	192.01
192.02	19202	THERAPY CASH BASED SERVICES	0	0	11,352	0	192.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,568,099	6,139,023	15,379,524	8,641,491	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24.770226	1.911218	0.307408	9,281.945220	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			45,236	25,687	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000904	27.590763	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: 14-0011

Period:
From 04/01/2019
To 03/31/2020

Worksheet B-1

Date/Time Prepared:
8/28/2020 9:15 am

Cost Center Description			CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	
			5.03	5A.04	5.04	6.00	8.00	
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	710,346,041					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	-14,461,344	121,787,967			5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	2,851,088	149,049		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	758,160	0	29,327	8.00
9.00	00900	HOUSEKEEPING	0	0	2,250,105	3,085	0	9.00
10.00	01000	DIETARY	0	0	1,063,862	3,470	0	10.00
11.00	01100	CAFETERIA	0	0	1,177,237	4,145	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	2,189,999	1,105	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	452,657	2,915	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	673,137	0	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	28,778,198	0	18,398,151	37,555	19,177	30.00
31.00	03100	INTENSIVE CARE UNIT	3,866,814	0	3,599,162	4,506	2,362	31.00
41.00	04100	SUBPROVIDER - IRF	15,647,019	0	6,287,775	17,272	7,788	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	124,295,009	0	15,485,735	27,290	0	50.00
51.00	05100	RECOVERY ROOM	9,124,770	0	1,360,585	4,201	0	51.00
53.00	05300	ANESTHESIOLOGY	18,581,430	0	1,187,824	28	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	40,536,517	0	5,034,798	6,829	0	54.00
56.00	05600	RADIOISOTOPE	16,589,630	0	1,462,543	1,436	0	56.00
57.00	05700	CT SCAN	85,890,491	0	1,997,295	1,020	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	25,063,642	0	1,311,018	731	0	58.00
60.00	06000	LABORATORY	114,862,590	0	9,112,208	5,657	0	60.00
65.00	06500	RESPIRATORY THERAPY	10,839,364	0	2,290,273	2,584	0	65.00
66.00	06600	PHYSICAL THERAPY	46,453,993	0	10,995,008	7,798	0	66.00
69.00	06900	ELECTROCARDIOLOGY	30,640,201	0	2,640,735	2,703	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,865,304	0	3,937,392	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,498,595	0	6,445,929	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,291,259	0	10,126,362	1,899	0	73.00
76.97	07697	CARDIAC REHABILITATION	2,633,720	0	740,817	1,878	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	6,986,870	0	811,977	0	0	90.00
91.00	09100	EMERGENCY	46,900,625	0	6,872,301	10,082	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)	710,346,041	-14,461,344	121,514,133	148,189	29,327	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	21,302	860	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	237,827	0	0	192.00
192.01	19201	OUTREACH LAB	0	0	0	0	0	192.01
192.02	19202	THERAPY CASH BASED SERVICES	0	0	14,705	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,239,240		14,461,344	3,189,632	848,185	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.005968		0.118742	21.399889	28.921642	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	47,780		1,081,317	738,706	7,410	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000067		0.008879	4.956129	0.252668	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: 14-0011

Period:
From 04/01/2019
To 03/31/2020

Worksheet B-1

Date/Time Prepared:
8/28/2020 9:15 am

Cost Center Description			HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NURSING HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	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
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	145,964					9.00
10.00	01000	DIETARY	3,470	92,763				10.00
11.00	01100	CAFETERIA	4,145	0	42,703,390			11.00
13.00	01300	NURSING ADMINISTRATION	1,105	0	1,017,770	733,855		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,915	0	232,568	0	4,247,544	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	389,147	0	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	37,555	62,313	9,507,722	301,990	32,974	30.00
31.00	03100	INTENSIVE CARE UNIT	4,506	7,086	1,966,418	46,695	10,082	31.00
41.00	04100	SUBPROVIDER - IRF	17,272	23,364	3,842,390	126,616	4,170	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	27,290	0	4,500,964	138,944	3,564,224	50.00
51.00	05100	RECOVERY ROOM	4,201	0	814,342	17,667	0	51.00
53.00	05300	ANESTHESIOLOGY	28	0	524,909	0	52,164	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,829	0	2,183,433	0	12,321	54.00
56.00	05600	RADIOISOTOPE	1,436	0	212,227	0	3,080	56.00
57.00	05700	CT SCAN	1,020	0	479,618	0	7,910	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	731	0	330,913	0	0	58.00
60.00	06000	LABORATORY	5,657	0	2,168,276	0	439,141	60.00
65.00	06500	RESPIRATORY THERAPY	2,584	0	1,256,514	0	88,043	65.00
66.00	06600	PHYSICAL THERAPY	7,798	0	5,940,673	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	2,703	0	1,260,337	0	1,008	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	2,406	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,899	0	2,207,122	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	1,878	0	403,804	0	275	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	254,693	0	4,912	90.00
91.00	09100	EMERGENCY	10,082	0	3,195,184	101,943	24,834	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)	145,104	92,763	42,689,024	733,855	4,247,544	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	860	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	3,014	0	0	192.00
192.01	19201	OUTREACH LAB	0	0	0	0	0	192.01
192.02	19202	THERAPY CASH BASED SERVICES	0	0	11,352	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,583,306	1,325,858	1,479,086	2,528,499	628,432	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	17.698241	14.292962	0.034636	3.445502	0.147952	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	146,445	139,461	138,603	758,633	109,810	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.003295	1.503412	0.003246	1.033764	0.025853	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: 14-0011

Period:
From 04/01/2019
To 03/31/2020

Worksheet B-1

Date/Time Prepared:
8/28/2020 9:15 am

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			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
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
16.00	01600	MEDICAL RECORDS & LIBRARY	710,346,041		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	28,778,198	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,866,814	0	31.00
41.00	04100	SUBPROVIDER - IRF	15,647,019	0	41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	124,295,009	0	50.00
51.00	05100	RECOVERY ROOM	9,124,770	0	51.00
53.00	05300	ANESTHESIOLOGY	18,581,430	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	40,536,517	0	54.00
56.00	05600	RADIOISOTOPE	16,589,630	0	56.00
57.00	05700	CT SCAN	85,890,491	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	25,063,642	0	58.00
60.00	06000	LABORATORY	114,862,590	0	60.00
65.00	06500	RESPIRATORY THERAPY	10,839,364	0	65.00
66.00	06600	PHYSICAL THERAPY	46,453,993	0	66.00
69.00	06900	ELECTROCARDIOLOGY	30,640,201	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,865,304	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,498,595	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,291,259	0	73.00
76.97	07697	CARDIAC REHABILITATION	2,633,720	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	6,986,870	0	90.00
91.00	09100	EMERGENCY	46,900,625	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)	710,346,041	100	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	OUTREACH LAB	0	0	192.01
192.02	19202	THERAPY CASH BASED SERVICES	0	0	192.02
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	766,545	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.001079	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	8,171	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000012	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: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet C
Part I
Date/Time Prepared:
8/28/2020 9:15 am

			Title XVIII	Hospital	PPS			
Cost Center Description			Therapy Limit Adj.	Costs				
				Total Costs	RCE		Total Costs	
					Disallowance			
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	24,902,138		24,902,138	6,862	24,909,000	30.00
31.00	03100	INTENSIVE CARE UNIT	4,606,964		4,606,964	0	4,606,964	31.00
41.00	04100	SUBPROVIDER - IRF	8,855,725		8,855,725	0	8,855,725	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	19,687,683		19,687,683	22,507	19,710,190	50.00
51.00	05100	RECOVERY ROOM	1,785,319		1,785,319	0	1,785,319	51.00
53.00	05300	ANESTHESIOLOGY	1,375,912		1,375,912	0	1,375,912	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,020,828		6,020,828	0	6,020,828	54.00
56.00	05600	RADIOISOTOPE	1,718,060		1,718,060	0	1,718,060	56.00
57.00	05700	CT SCAN	2,384,796		2,384,796	0	2,384,796	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,533,777		1,533,777	0	1,533,777	58.00
60.00	06000	LABORATORY	10,679,397		10,679,397	0	10,679,397	60.00
65.00	06500	RESPIRATORY THERAPY	2,731,497	0	2,731,497	945	2,732,442	65.00
66.00	06600	PHYSICAL THERAPY	12,861,349	0	12,861,349	0	12,861,349	66.00
69.00	06900	ELECTROCARDIOLOGY	3,136,846		3,136,846	0	3,136,846	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,427,796		4,427,796	0	4,427,796	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,234,529		7,234,529	0	7,234,529	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,522,953		11,522,953	0	11,522,953	73.00
76.97	07697	CARDIAC REHABILITATION	919,078		919,078	1,253	920,331	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	925,481		925,481	690	926,171	90.00
91.00	09100	EMERGENCY	8,598,713		8,598,713	3,101	8,601,814	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,427,689		2,427,689		2,427,689	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	138,336,530	0	138,336,530	35,358	138,371,888	200.00
201.00		Less Observation Beds	2,427,689		2,427,689		2,427,689	201.00
202.00		Total (see instructions)	135,908,841	0	135,908,841	35,358	135,944,199	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet C
Part I
Date/Time Prepared:
8/28/2020 9:15 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	23,695,346		23,695,346			30.00
31.00	03100	INTENSIVE CARE UNIT	3,866,814		3,866,814			31.00
41.00	04100	SUBPROVIDER - IRF	14,055,081		14,055,081			41.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	41,065,328	81,284,124	122,349,452	0.160914	0.000000	50.00
51.00	05100	RECOVERY ROOM	3,698,796	4,918,584	8,617,380	0.207177	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	6,014,517	12,176,168	18,190,685	0.075638	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,788,794	33,770,394	39,559,188	0.152198	0.000000	54.00
56.00	05600	RADIOISOTOPE	2,585,873	13,655,335	16,241,208	0.105784	0.000000	56.00
57.00	05700	CT SCAN	24,277,635	60,597,325	84,874,960	0.028098	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,539,736	19,868,456	24,408,192	0.062839	0.000000	58.00
60.00	06000	LABORATORY	27,136,121	85,647,382	112,783,503	0.094689	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	8,225,252	2,570,636	10,795,888	0.253013	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	16,655,687	28,495,553	45,151,240	0.284850	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	10,243,613	20,118,499	30,362,112	0.103314	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,628,023	10,960,045	20,588,068	0.215066	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,217,587	7,042,918	21,260,505	0.340280	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,325,065	13,687,940	40,013,005	0.287980	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	1,427	2,601,237	2,602,664	0.353130	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	132,144	6,824,189	6,956,333	0.133042	0.000000	90.00
91.00	09100	EMERGENCY	12,248,859	34,131,618	46,380,477	0.185395	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	641,081	4,380,561	5,021,642	0.483445	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	255,042,779	442,730,964	697,773,743			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	255,042,779	442,730,964	697,773,743			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-0011	Period: From 04/01/2019 To 03/31/2020	Worksheet C Part I Date/Time Prepared: 8/28/2020 9:15 am
				Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio			
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
41.00	04100	SUBPROVIDER - IRF				41.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.161097			50.00
51.00	05100	RECOVERY ROOM	0.207177			51.00
53.00	05300	ANESTHESIOLOGY	0.075638			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.152198			54.00
56.00	05600	RADIOISOTOPE	0.105784			56.00
57.00	05700	CT SCAN	0.028098			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.062839			58.00
60.00	06000	LABORATORY	0.094689			60.00
65.00	06500	RESPIRATORY THERAPY	0.253100			65.00
66.00	06600	PHYSICAL THERAPY	0.284850			66.00
69.00	06900	ELECTROCARDIOLOGY	0.103314			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.215066			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.340280			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.287980			73.00
76.97	07697	CARDIAC REHABILITATION	0.353611			76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.133141			90.00
91.00	09100	EMERGENCY	0.185462			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.483445			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: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet C
Part I
Date/Time Prepared:
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			Title XIX	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Total Costs
			1.00	2.00	3.00	4.00
						5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,902,138		24,902,138	0
31.00	03100	INTENSIVE CARE UNIT	4,606,964		4,606,964	0
41.00	04100	SUBPROVIDER - IRF	8,855,725		8,855,725	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,687,683		19,687,683	0
51.00	05100	RECOVERY ROOM	1,785,319		1,785,319	0
53.00	05300	ANESTHESIOLOGY	1,375,912		1,375,912	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,020,828		6,020,828	0
56.00	05600	RADIOISOTOPE	1,718,060		1,718,060	0
57.00	05700	CT SCAN	2,384,796		2,384,796	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,533,777		1,533,777	0
60.00	06000	LABORATORY	10,679,397		10,679,397	0
65.00	06500	RESPIRATORY THERAPY	2,731,497	0	2,731,497	0
66.00	06600	PHYSICAL THERAPY	12,861,349	0	12,861,349	0
69.00	06900	ELECTROCARDIOLOGY	3,136,846		3,136,846	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,427,796		4,427,796	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,234,529		7,234,529	0
73.00	07300	DRUGS CHARGED TO PATIENTS	11,522,953		11,522,953	0
76.97	07697	CARDIAC REHABILITATION	919,078		919,078	0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	925,481		925,481	0
91.00	09100	EMERGENCY	8,598,713		8,598,713	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0	0
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
200.00		Subtotal (see instructions)	135,908,841	0	135,908,841	0
201.00		Less Observation Beds	0		0	0
202.00		Total (see instructions)	135,908,841	0	135,908,841	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet C
Part I
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			Title XIX		Hospital	Cost		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0		0			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	0	0	0			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	0	0	0			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
41.00	04100	SUBPROVIDER - IRF				41.00
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
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
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 ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part I
Date/Time Prepared:
8/28/2020 9:15 am

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,000,553	0	2,000,553	23,014	86.93	30.00
31.00	INTENSIVE CARE UNIT	336,968		336,968	2,362	142.66	31.00
41.00	SUBPROVIDER - IRF	865,467	0	865,467	7,788	111.13	41.00
200.00	Total (lines 30 through 199)	3,202,988		3,202,988	33,164		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	12,392	1,077,237				30.00
31.00	INTENSIVE CARE UNIT	1,341	191,307				31.00
41.00	SUBPROVIDER - IRF	4,980	553,427				41.00
200.00	Total (lines 30 through 199)	18,713	1,821,971				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part II
Date/Time Prepared:
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				Title XVIII		Hospital	PPS	
Cost Center Description			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	3,862,671	122,349,452	0.031571	20,538,763	648,429	50.00
51.00	05100	RECOVERY ROOM	172,631	8,617,380	0.020033	1,826,143	36,583	51.00
53.00	05300	ANESTHESIOLOGY	80,235	18,190,685	0.004411	2,926,041	12,907	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,113,467	39,559,188	0.028147	2,722,117	76,619	54.00
56.00	05600	RADIOISOTOPE	65,013	16,241,208	0.004003	1,662,531	6,655	56.00
57.00	05700	CT SCAN	410,898	84,874,960	0.004841	13,175,610	63,783	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	343,706	24,408,192	0.014082	2,048,485	28,847	58.00
60.00	06000	LABORATORY	526,151	112,783,503	0.004665	15,379,092	71,743	60.00
65.00	06500	RESPIRATORY THERAPY	204,223	10,795,888	0.018917	4,674,314	88,424	65.00
66.00	06600	PHYSICAL THERAPY	424,497	45,151,240	0.009402	3,735,911	35,125	66.00
69.00	06900	ELECTROCARDIOLOGY	179,862	30,362,112	0.005924	6,185,344	36,642	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	36,670	20,588,068	0.001781	4,560,963	8,123	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	58,931	21,260,505	0.002772	7,532,130	20,879	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	212,793	40,013,005	0.005318	13,373,047	71,118	73.00
76.97	07697	CARDIAC REHABILITATION	84,742	2,602,664	0.032560	1,294	42	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	39,513	6,956,333	0.005680	124,726	708	90.00
91.00	09100	EMERGENCY	635,311	46,380,477	0.013698	6,821,497	93,441	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	194,977	5,021,642	0.038827	514,250	19,967	92.00
200.00		Total (lines 50 through 199)	8,646,291	656,156,502		107,802,258	1,320,035	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS						Provider CCN: 14-0011		Period: From 04/01/2019 To 03/31/2020		Worksheet D Part III Date/Time Prepared: 8/28/2020 9:15 am	
						Title XVIII		Hospital		PPS	
Cost Center Description						Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
						1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0		0		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0	0		0		0		31.00
41.00	04100	SUBPROVIDER - IRF		0	0		0		0		41.00
200.00		Total (lines 30 through 199)		0	0		0		0		200.00
Cost Center Description						Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
						4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0		23,014		0.00	12,392	30.00
31.00	03100	INTENSIVE CARE UNIT			0		2,362		0.00	1,341	31.00
41.00	04100	SUBPROVIDER - IRF		0	0		7,788		0.00	4,980	41.00
200.00		Total (lines 30 through 199)			0		33,164			18,713	200.00
Cost Center Description						Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost				
						9.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0						
31.00	03100	INTENSIVE CARE UNIT		0	0						
41.00	04100	SUBPROVIDER - IRF		0	0						
200.00		Total (lines 30 through 199)		0	0						

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
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	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part IV
Date/Time Prepared:
8/28/2020 9:15 am

				Title XVIII		Hospital	PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	122,349,452	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	8,617,380	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	18,190,685	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	39,559,188	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	16,241,208	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	84,874,960	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	24,408,192	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	112,783,503	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,795,888	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	45,151,240	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	30,362,112	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	20,588,068	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	21,260,505	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	40,013,005	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	2,602,664	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	6,956,333	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	46,380,477	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	5,021,642	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	656,156,502		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part IV
Date/Time Prepared:
8/28/2020 9:15 am

Cost Center Description			Title XVIII		Hospital		PPS	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	20,538,763	0	23,831,966	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	1,826,143	0	1,515,640	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	2,926,041	0	3,629,478	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,722,117	0	9,322,880	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	1,662,531	0	6,725,765	0	56.00
57.00	05700	CT SCAN	0.000000	13,175,610	0	23,517,317	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	2,048,485	0	7,513,584	0	58.00
60.00	06000	LABORATORY	0.000000	15,379,092	0	9,630,884	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	4,674,314	0	1,148,327	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	3,735,911	0	35,041	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	6,185,344	0	8,337,032	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	4,560,963	0	3,091,756	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	7,532,130	0	2,071,886	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	13,373,047	0	4,428,966	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	1,294	0	958,552	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	124,726	0	3,471,665	0	90.00
91.00	09100	EMERGENCY	0.000000	6,821,497	0	9,484,900	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	514,250	0	1,963,427	0	92.00
200.00		Total (lines 50 through 199)		107,802,258	0	120,679,066	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0011		Period: From 04/01/2019 To 03/31/2020		Worksheet D Part IV Date/Time Prepared: 8/28/2020 9:15 am	
				Title XVIII		Hospital		PPS	
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					
51.00	05100	RECOVERY ROOM	0	0					
53.00	05300	ANESTHESIOLOGY	0	0					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					
56.00	05600	RADIOISOTOPE	0	0					
57.00	05700	CT SCAN	0	0					
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0					
60.00	06000	LABORATORY	0	0					
65.00	06500	RESPIRATORY THERAPY	0	0					
66.00	06600	PHYSICAL THERAPY	0	0					
69.00	06900	ELECTROCARDIOLOGY	0	0					
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0					
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					
76.97	07697	CARDIAC REHABILITATION	0	0					
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0					
91.00	09100	EMERGENCY	0	0					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0					
200.00		Total (lines 50 through 199)	0	0					

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part V
Date/Time Prepared:
8/28/2020 9:15 am

				Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.160914	23,831,966	0	0	3,834,897	50.00	
51.00	05100	RECOVERY ROOM	0.207177	1,515,640	0	0	314,006	51.00	
53.00	05300	ANESTHESIOLOGY	0.075638	3,629,478	0	0	274,526	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.152198	9,322,880	0	0	1,418,924	54.00	
56.00	05600	RADIOISOTOPE	0.105784	6,725,765	0	0	711,478	56.00	
57.00	05700	CT SCAN	0.028098	23,517,317	0	0	660,790	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.062839	7,513,584	0	0	472,146	58.00	
60.00	06000	LABORATORY	0.094689	9,630,884	0	0	911,939	60.00	
65.00	06500	RESPIRATORY THERAPY	0.253013	1,148,327	0	0	290,542	65.00	
66.00	06600	PHYSICAL THERAPY	0.284850	35,041	0	0	9,981	66.00	
69.00	06900	ELECTROCARDIOLOGY	0.103314	8,337,032	0	0	861,332	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.215066	3,091,756	0	0	664,932	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.340280	2,071,886	0	0	705,021	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.287980	4,428,966	0	42,350	1,275,454	73.00	
76.97	07697	CARDIAC REHABILITATION	0.353130	958,552	0	0	338,493	76.97	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.133042	3,471,665	0	0	461,877	90.00	
91.00	09100	EMERGENCY	0.185395	9,484,900	0	0	1,758,453	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.483445	1,963,427	0	0	949,209	92.00	
200.00		Subtotal (see instructions)		120,679,066	0	42,350	15,914,000	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		120,679,066	0	42,350	15,914,000	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part V
Date/Time Prepared:
8/28/2020 9:15 am

				Title XVIII	Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
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
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	12,196		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	12,196		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	12,196		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0011	Period: From 04/01/2019 To 03/31/2020	Worksheet D Part II Date/Time Prepared: 8/28/2020 9:15 am		
				Component CCN: 14-T011				
				Title XVIII		Subprovider - IRF	PPS	
Cost Center Description			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	3,862,671	122,349,452	0.031571	60,647	1,915	50.00
51.00	05100	RECOVERY ROOM	172,631	8,617,380	0.020033	1,775	36	51.00
53.00	05300	ANESTHESIOLOGY	80,235	18,190,685	0.004411	1,993	9	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,113,467	39,559,188	0.028147	177,655	5,000	54.00
56.00	05600	RADIOISOTOPE	65,013	16,241,208	0.004003	11,568	46	56.00
57.00	05700	CT SCAN	410,898	84,874,960	0.004841	309,820	1,500	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	343,706	24,408,192	0.014082	44,294	624	58.00
60.00	06000	LABORATORY	526,151	112,783,503	0.004665	836,323	3,901	60.00
65.00	06500	RESPIRATORY THERAPY	204,223	10,795,888	0.018917	500,840	9,474	65.00
66.00	06600	PHYSICAL THERAPY	424,497	45,151,240	0.009402	7,016,497	65,969	66.00
69.00	06900	ELECTROCARDIOLOGY	179,862	30,362,112	0.005924	68,848	408	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	36,670	20,588,068	0.001781	32,397	58	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	58,931	21,260,505	0.002772	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	212,793	40,013,005	0.005318	1,617,648	8,603	73.00
76.97	07697	CARDIAC REHABILITATION	84,742	2,602,664	0.032560	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	39,513	6,956,333	0.005680	7,418	42	90.00
91.00	09100	EMERGENCY	635,311	46,380,477	0.013698	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,021,642	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	8,451,314	656,156,502		10,687,723	97,585	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0011 Component CCN: 14-T011		Period: From 04/01/2019 To 03/31/2020		Worksheet D Part IV Date/Time Prepared: 8/28/2020 9:15 am	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	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
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
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: 14-0011 Component CCN: 14-T011		Period: From 04/01/2019 To 03/31/2020		Worksheet D Part IV Date/Time Prepared: 8/28/2020 9:15 am	
			Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	122,349,452	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	8,617,380	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	18,190,685	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	39,559,188	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	16,241,208	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	84,874,960	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	24,408,192	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	112,783,503	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,795,888	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	45,151,240	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	30,362,112	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	20,588,068	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	21,260,505	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	40,013,005	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	2,602,664	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	6,956,333	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	46,380,477	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	5,021,642	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	656,156,502		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0011 Component CCN: 14-T011		Period: From 04/01/2019 To 03/31/2020		Worksheet D Part IV Date/Time Prepared: 8/28/2020 9:15 am	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000		60,647		0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000		1,775		0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000		1,993		0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		177,655		0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000		11,568		0	0	56.00
57.00	05700	CT SCAN	0.000000		309,820		0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		44,294		0	0	58.00
60.00	06000	LABORATORY	0.000000		836,323		0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		500,840		0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000		7,016,497		0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		68,848		0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		32,397		0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		0		0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		1,617,648		0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000		0		0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000		7,418		0	0	90.00
91.00	09100	EMERGENCY	0.000000		0		0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		0		0	0	92.00
200.00		Total (lines 50 through 199)			10,687,723		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0011 Component CCN: 14-T011		Period: From 04/01/2019 To 03/31/2020		Worksheet D Part IV Date/Time Prepared: 8/28/2020 9:15 am	
				Title XVIII		Subprovider - IRF		PPS	
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	
56.00	05600	RADIOISOTOPE	0	0				56.00	
57.00	05700	CT SCAN	0	0				57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00	
60.00	06000	LABORATORY	0	0				60.00	
65.00	06500	RESPIRATORY THERAPY	0	0				65.00	
66.00	06600	PHYSICAL THERAPY	0	0				66.00	
69.00	06900	ELECTROCARDIOLOGY	0	0				69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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 INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part I
Date/Time Prepared:
8/28/2020 9:15 am

			Title XIX		Hospital	Cost	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,000,553	0	2,000,553	23,014	86.93	30.00
31.00	INTENSIVE CARE UNIT	336,968		336,968	2,362	142.66	31.00
41.00	SUBPROVIDER - IRF	865,467	0	865,467	7,788	111.13	41.00
200.00	Total (lines 30 through 199)	3,202,988		3,202,988	33,164		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	408	35,467				30.00
31.00	INTENSIVE CARE UNIT	42	5,992				31.00
41.00	SUBPROVIDER - IRF	319	35,450				41.00
200.00	Total (lines 30 through 199)	769	76,909				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part II
Date/Time Prepared:
8/28/2020 9:15 am

Cost Center Description		Title XIX		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	3,862,671	0	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	172,631	0	0.000000	0	51.00
53.00	05300	ANESTHESIOLOGY	80,235	0	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,113,467	0	0.000000	0	54.00
56.00	05600	RADIOISOTOPE	65,013	0	0.000000	0	56.00
57.00	05700	CT SCAN	410,898	0	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	343,706	0	0.000000	0	58.00
60.00	06000	LABORATORY	526,151	0	0.000000	0	60.00
65.00	06500	RESPIRATORY THERAPY	204,223	0	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	424,497	0	0.000000	0	66.00
69.00	06900	ELECTROCARDIOLOGY	179,862	0	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	36,670	0	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	58,931	0	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	212,793	0	0.000000	0	73.00
76.97	07697	CARDIAC REHABILITATION	84,742	0	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	39,513	0	0.000000	0	90.00
91.00	09100	EMERGENCY	635,311	0	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0	92.00
200.00		Total (lines 50 through 199)	8,451,314	0		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0011		Period: From 04/01/2019 To 03/31/2020		Worksheet D Part III Date/Time Prepared: 8/28/2020 9:15 am	
					Title XIX		Hospital		Cost	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF		0	0	0	0	0	0	41.00
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
					4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	23,014	0.00		408	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	2,362	0.00		42	31.00
41.00	04100	SUBPROVIDER - IRF		0	0	7,788	0.00		319	41.00
200.00		Total (lines 30 through 199)		0	0	33,164			769	200.00
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost				
					9.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0					30.00
31.00	03100	INTENSIVE CARE UNIT		0	0					31.00
41.00	04100	SUBPROVIDER - IRF		0	0					41.00
200.00		Total (lines 30 through 199)		0	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0011		Period: From 04/01/2019 To 03/31/2020		Worksheet D Part IV Date/Time Prepared: 8/28/2020 9:15 am	
				Title XIX		Hospital		Cost	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	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
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
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	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: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part IV
Date/Time Prepared:
8/28/2020 9:15 am

Cost Center Description			Title XIX		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) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	0	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part IV
Date/Time Prepared:
8/28/2020 9:15 am

Cost Center Description			Title XIX		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	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part IV
Date/Time Prepared:
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				Title XIX		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
56.00	05600	RADIOISOTOPE	0	0					56.00
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0					58.00
60.00	06000	LABORATORY	0	0					60.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020

Worksheet D-1

Date/Time Prepared:
8/28/2020 9:15 am

Title XVIII		Hospital	PPS
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	23,014	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	23,014	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)	20,771	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	12,392	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	24,909,000	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	24,909,000	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)	24,909,000	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)	1,082.34	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	13,412,357	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)	13,412,357	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020

Worksheet D-1

Date/Time Prepared:
8/28/2020 9:15 am

Cost Center Description		Title XVIII			Hospital	PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,606,964	2,362	1,950.45	1,341	2,615,553	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)					18,265,913	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					34,293,823	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)					1,268,544	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,320,035	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,588,579	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					31,705,244	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					2,243	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,082.34	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,427,689	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020

Worksheet D-1

Date/Time Prepared:
8/28/2020 9:15 am

		Title XVIII		Hospital		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,000,553	24,909,000	0.080314	2,427,689	194,977	90.00
91.00	Nursing School cost	0	24,909,000	0.000000	2,427,689	0	91.00
92.00	Allied health cost	0	24,909,000	0.000000	2,427,689	0	92.00
93.00	All other Medical Education	0	24,909,000	0.000000	2,427,689	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0011 Component CCN: 14-T011	Period: From 04/01/2019 To 03/31/2020	Worksheet D-1 Date/Time Prepared: 8/28/2020 9:15 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,788	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,788	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)		7,788	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		4,980	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		8,855,725	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		8,855,725	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		8,855,725	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)		1,137.10	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,662,758	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)		5,662,758	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0011

Period:

Worksheet D-1

Component CCN: 14-T011

From 04/01/2019
To 03/31/2020Date/Time Prepared:
8/28/2020 9:15 am

Title XVIII

Subprovider -

PPS

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,735,561	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					8,398,319	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)					553,427	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					97,585	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					651,012	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					7,747,307	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0011 Component CCN: 14-T011		Period: From 04/01/2019 To 03/31/2020	Worksheet D-1 Date/Time Prepared: 8/28/2020 9:15 am	
		Title XVIII		Subprovider - IRF	PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	865,467	8,855,725	0.097730	0	0 90.00
91.00	Nursing School cost	0	8,855,725	0.000000	0	0 91.00
92.00	Allied health cost	0	8,855,725	0.000000	0	0 92.00
93.00	All other Medical Education	0	8,855,725	0.000000	0	0 93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0011	Period: From 04/01/2019 To 03/31/2020	Worksheet D-3 Date/Time Prepared: 8/28/2020 9:15 am	
			Title XVIII	Hospital	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		11,861,037		30.00
31.00	03100	INTENSIVE CARE UNIT		2,062,193		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.161097	20,538,763	3,308,733	50.00
51.00	05100	RECOVERY ROOM	0.207177	1,826,143	378,335	51.00
53.00	05300	ANESTHESIOLOGY	0.075638	2,926,041	221,320	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.152198	2,722,117	414,301	54.00
56.00	05600	RADIOISOTOPE	0.105784	1,662,531	175,869	56.00
57.00	05700	CT SCAN	0.028098	13,175,610	370,208	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.062839	2,048,485	128,725	58.00
60.00	06000	LABORATORY	0.094689	15,379,092	1,456,231	60.00
65.00	06500	RESPIRATORY THERAPY	0.253100	4,674,314	1,183,069	65.00
66.00	06600	PHYSICAL THERAPY	0.284850	3,735,911	1,064,174	66.00
69.00	06900	ELECTROCARDIOLOGY	0.103314	6,185,344	639,033	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.215066	4,560,963	980,908	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.340280	7,532,130	2,563,033	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.287980	13,373,047	3,851,170	73.00
76.97	07697	CARDIAC REHABILITATION	0.353611	1,294	458	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.133141	124,726	16,606	90.00
91.00	09100	EMERGENCY	0.185462	6,821,497	1,265,128	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.483445	514,250	248,612	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		107,802,258	18,265,913	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)		107,802,258		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0011 Component CCN: 14-T011	Period: From 04/01/2019 To 03/31/2020	Worksheet D-3 Date/Time Prepared: 8/28/2020 9:15 am	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
41.00	04100 SUBPROVIDER - IRF		9,094,807		41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.161097	60,647	9,770	50.00
51.00	05100 RECOVERY ROOM	0.207177	1,775	368	51.00
53.00	05300 ANESTHESIOLOGY	0.075638	1,993	151	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.152198	177,655	27,039	54.00
56.00	05600 RADIOISOTOPE	0.105784	11,568	1,224	56.00
57.00	05700 CT SCAN	0.028098	309,820	8,705	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.062839	44,294	2,783	58.00
60.00	06000 LABORATORY	0.094689	836,323	79,191	60.00
65.00	06500 RESPIRATORY THERAPY	0.253100	500,840	126,763	65.00
66.00	06600 PHYSICAL THERAPY	0.284850	7,016,497	1,998,649	66.00
69.00	06900 ELECTROCARDIOLOGY	0.103314	68,848	7,113	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.215066	32,397	6,967	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.340280	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.287980	1,617,648	465,850	73.00
76.97	07697 CARDIAC REHABILITATION	0.353611	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.133141	7,418	988	90.00
91.00	09100 EMERGENCY	0.185462	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.483445	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		10,687,723	2,735,561	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)		10,687,723		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet E
Part A
Date/Time Prepared:
8/28/2020 9:15 am

		Title XVIII	Hospital	PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			12,182,133	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			13,188,286	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)			0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)			0	1.04
2.00	Outlier payments for discharges. (see instructions)				2.00
2.01	Outlier reconciliation amount			0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)			0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)			199,548	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			172,583	2.04
3.00	Managed Care Simulated Payments			0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			78.87	4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)			0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)			0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)			0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00	11.00
12.00	Current year allowable FTE (see instructions)			0.00	12.00
13.00	Total allowable FTE count for the prior year.			0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.			0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.00	15.00
16.00	Adjustment for residents in initial years of the program			0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00	17.00
18.00	Adjusted rolling average FTE count			0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	21.00
22.00	IME payment adjustment (see instructions)			0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).			0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)			0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)			0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)			0	28.01
29.00	Total IME payment (sum of lines 22 and 28)			0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			5.24	30.00
31.00	Percentage of Medicaid patient days (see instructions)			16.07	31.00
32.00	Sum of lines 30 and 31			21.31	32.00
33.00	Allowable disproportionate share percentage (see instructions)			6.80	33.00
34.00	Disproportionate share adjustment (see instructions)			431,297	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0011	Period: From 04/01/2019 To 03/31/2020	Worksheet E Part A Date/Time Prepared: 8/28/2020 9:15 am	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,038,947	1,313,512		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	520,897	656,756		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,177,653			36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0			43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0			46.00
47.00	Subtotal (see instructions)	27,351,500			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	31,297,168			48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)		30,310,751		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,051,177		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
54.01	Islet isolation add-on payment		0		54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		32,361,928		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		32,361,928		61.00
62.00	Deductibles billed to program beneficiaries		3,055,976		62.00
63.00	Coinsurance billed to program beneficiaries		66,902		63.00
64.00	Allowable bad debts (see instructions)		1,161,603		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		755,042		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		947,538		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		29,994,092		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0		70.50
70.87	Demonstration payment adjustment amount before sequestration		0		70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0		70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)				70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		-23,969		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		-74,425		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		-206,471		70.93
70.94	HRR adjustment amount (see instructions)		-637,614		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0011	Period: From 04/01/2019 To 03/31/2020	Worksheet E Part A Date/Time Prepared: 8/28/2020 9:15 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		29,051,613	71.00
71.01	Sequestration adjustment (see instructions)		581,032	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		27,236,220	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		1,234,361	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		48,994	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		1,479,626	100.00
HVPB Adjustment for HSP Bonus Payment				
101.00	HVPB adjustment factor (see instructions)		0.9928703878	101.00
102.00	HVPB adjustment amount for HSP bonus payment (see instructions)		-10,549	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.9744	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		-37,878	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF DSH PAYMENT PERCENTAGE

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020

Worksheet DSH

Date/Time Prepared:
8/28/2020 9:15 am

		Title XVIII		Hospital		PPS	
		Original .mcx Values	Adjusted .mcx Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	5.24	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	16.07	0.00			16.07	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	21.31	0.00			16.07	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	MDH				MDH	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	78.87	0.00			78.87	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	6.80	0.00			0.00	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	No				No	9.00
10.00	S-2, Line 45	No				No	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	Yes				Yes	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	3.71	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	327	0			327	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	123	0			123	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	3,171	0			3,171	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	97	0			97	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	3,718	0			3,718	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	23,133	0			23,133	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	0	0			0	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	23,133	0			23,133	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	16.07	0.00			16.07	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 14-0011		Period: From 04/01/2019 To 03/31/2020		Worksheet DSH Date/Time Prepared: 8/28/2020 9:15 am	
		Title XVIII		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	6.80		0.00	False	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	True	29.00
30.00	Line 28 or 29 as applicable		6.80		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		6.80		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
DETERMINATION OF PROVIDER TYPE							
32.00	Does the hospital qualify under the Pickle ammendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	True				True	34.00
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Rural				Rural	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020

Worksheet DSH

Date/Time Prepared:
8/28/2020 9:15 am

Title XVIII

Hospital

PPS

		Revised		
		Percentage		
		6.00		
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE			
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	0.00		28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	3.20		29.00
30.00	Line 28 or 29 as applicable	3.20		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	0.00		31.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0011	Period: From 04/01/2019 To 03/31/2020	Worksheet E Part B Date/Time Prepared: 8/28/2020 9:15 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		12,196	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		15,914,000	2.00
3.00	OPPS payments		12,165,385	3.00
4.00	Outlier payment (see instructions)		40,121	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.804	5.00
6.00	Line 2 times line 5		12,794,856	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		95.39	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)		12,196	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		42,350	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)		42,350	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)		42,350	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		30,154	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)		12,196	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)		12,205,506	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,496,572	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)		9,721,130	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)		9,721,130	30.00
31.00	Primary payer payments		334	31.00
32.00	Subtotal (line 30 minus line 31)		9,720,796	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)		706,293	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		459,090	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		583,094	36.00
37.00	Subtotal (see instructions)		10,179,886	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		10,179,886	40.00
40.01	Sequestration adjustment (see instructions)		203,598	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		10,068,092	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		-91,804	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
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: 14-0011	Period: From 04/01/2019 To 03/31/2020	Worksheet E Part B Date/Time Prepared: 8/28/2020 9:15 am	
		Title XVIII	Hospital	PPS	
				Overrides	
				1.00	
WORKSHEET OVERRIDE VALUES					
112.00	Override of Ancillary service charges (line 12)				0112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet E-1
Part I
Date/Time Prepared:
8/28/2020 9:15 am

		Title XVIII		Hospital	PPS	
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		28,546,953		10,055,855	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0	10/23/2019	12,237	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51		10/23/2019	1,310,733		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)		-1,310,733		12,237	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)		27,236,220		10,068,092	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		1,234,361		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		91,804	6.02
7.00	Total Medicare program liability (see instructions)		28,470,581		9,976,288	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: 14-0011 Component CCN: 14-T011	Period: From 04/01/2019 To 03/31/2020	Worksheet E-1 Part I Date/Time Prepared: 8/28/2020 9:15 am	
		Title XVIII	Subprovider - IRF	PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider				0 1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		6,556,950		0 2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0 3.01
3.02		10/23/2019	6,141		0 3.02
3.03			0		0 3.03
3.04			0		0 3.04
3.05			0		0 3.05
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0 3.50
3.51			0		0 3.51
3.52			0		0 3.52
3.53			0		0 3.53
3.54			0		0 3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		6,141		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)		6,563,091		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		24,448		0 6.02
7.00	Total Medicare program liability (see instructions)		6,538,643		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: 14-0011	Period: From 04/01/2019 To 03/31/2020	Worksheet E-1 Part II Date/Time Prepared: 8/28/2020 9:15 am	
		Title XVIII	Hospital	PPS	
				1.00	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14				1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20				6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168				7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)				10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)				32.00
				Overrides	
				1.00	
CONTRACTOR OVERRIDES					
108.00	Override of HIT payment				108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0011 Component CCN: 14-T011	Period: From 04/01/2019 To 03/31/2020	Worksheet E-3 Part III Date/Time Prepared: 8/28/2020 9:15 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
	PART III - MEDICARE PART A SERVICES - IRF PPS			
1.00	Net Federal PPS Payment (see instructions)			5,392,978 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0371 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			244,841 3.00
4.00	Outlier Payments			1,171,683 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			21.278689 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			6,809,502 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			6,809,502 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			6,809,502 19.00
20.00	Deductibles			86,240 20.00
21.00	Subtotal (line 19 minus line 20)			6,723,262 21.00
22.00	Coinurance			80,036 22.00
23.00	Subtotal (line 21 minus line 22)			6,643,226 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			44,399 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			28,859 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			44,273 26.00
27.00	Subtotal (sum of lines 23 and 25)			6,672,085 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			6,672,085 32.00
32.01	Sequestration adjustment (see instructions)			133,442 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			6,563,091 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			-24,448 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			1,171,683 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

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

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020

Worksheet G

Date/Time Prepared:
8/28/2020 9:15 am

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	6,318,437	0	12,765	0	1.00
2.00 Temporary investments	0	0	0	0	2.00
3.00 Notes receivable	23,337	0	0	0	3.00
4.00 Accounts receivable	115,401,065	0	0	0	4.00
5.00 Other receivable	0	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-92,883,649	0	0	0	6.00
7.00 Inventory	3,080,461	0	0	0	7.00
8.00 Prepaid expenses	379,738	0	0	0	8.00
9.00 Other current assets	734,560	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)	33,053,949	0	12,765	0	11.00
FIXED ASSETS					
12.00 Land	5,070,283	0	0	0	12.00
13.00 Land improvements	5,896,810	0	0	0	13.00
14.00 Accumulated depreciation	-3,874,673	0	0	0	14.00
15.00 Buildings	96,241,403	0	0	0	15.00
16.00 Accumulated depreciation	-54,968,264	0	0	0	16.00
17.00 Leasehold improvements	35,549	0	0	0	17.00
18.00 Accumulated depreciation	-14,777	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	250,222	0	0	0	21.00
22.00 Accumulated depreciation	-230,231	0	0	0	22.00
23.00 Major movable equipment	36,491,960	0	0	0	23.00
24.00 Accumulated depreciation	-23,818,325	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	458,230	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	61,538,187	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	26,995	0	0	0	31.00
32.00 Deposits on leases	0	0	0	0	32.00
33.00 Due from owners/officers	0	0	0	0	33.00
34.00 Other assets	1,414,153	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	1,441,148	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	96,033,284	0	12,765	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	4,620,257	0	0	0	37.00
38.00 Salaries, wages, and fees payable	5,215,421	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	844,265	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	5,189,272	0	0	0	43.00
44.00 Other current liabilities	1,442,165	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	17,311,380	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	38,238,318	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	7,445,149	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	45,683,467	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	62,994,847	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	33,038,437	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	12,765	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)	33,038,437	0	12,765	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	96,033,284	0	12,765	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020

Worksheet G-1

Date/Time Prepared:
8/28/2020 9:15 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		37,685,175		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-4,646,738				2.00
3.00	Total (sum of line 1 and line 2)		33,038,437		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00	TRAUMA FUND	0		0		14,098	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		33,038,437		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00	PURCHASES	0		0		9,207	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		33,038,437		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	7,874		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)	7,874		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00	TRAUMA FUND		0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	14,098		0			10.00
11.00	Subtotal (line 3 plus line 10)	21,972		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00	PURCHASES		0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	9,207		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	12,765		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
8/28/2020 9:15 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	28,729,634		28,729,634	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	14,531,266		14,531,266	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	43,260,900		43,260,900	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,866,814		3,866,814	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)	3,866,814		3,866,814	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	47,127,714		47,127,714	17.00
18.00	Ancillary services	212,759,028	450,459,300	663,218,328	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)	259,886,742	450,459,300	710,346,042	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		137,551,807		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)		137,551,807		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0011

Period:
From 04/01/2019
To 03/31/2020

Worksheet G-3

Date/Time Prepared:
8/28/2020 9:15 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	710,346,042	1.00
2.00	Less contractual allowances and discounts on patients' accounts	530,045,960	2.00
3.00	Net patient revenues (line 1 minus line 2)	180,300,082	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	137,551,807	4.00
5.00	Net income from service to patients (line 3 minus line 4)	42,748,275	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	35,294	6.00
7.00	Income from investments	-283,713	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	4,446	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	648,835	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	1,494	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	51,790	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	541,014	22.00
23.00	Governmental appropriations	25,849	23.00
24.00	MISC., PHO, DEPARTMENTAL	10,537	24.00
25.00	Total other income (sum of lines 6-24)	1,035,546	25.00
26.00	Total (line 5 plus line 25)	43,783,821	26.00
27.00	CORP ALLOC., CONTR., LOSS ON EQUIP	48,430,559	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	48,430,559	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-4,646,738	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0011	Period: From 04/01/2019 To 03/31/2020	Worksheet L Parts I-III Date/Time Prepared: 8/28/2020 9:15 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		2,013,206	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		37,971	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		63.20	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		2,051,177	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00