

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: 14-0040	Period: From 05/01/2019 To 04/30/2020	Worksheet S Parts I-III Date/Time Prepared: 9/30/2020 11:54 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 9/30/2020	Time: 11:54 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 GALESBURG COTTAGE HOSPITAL (14-0040) for the cost reporting period beginning 05/01/2019 and ending 04/30/2020 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) RANDY COOPER

Officer or Administrator of Provider(s)

SENIOR VICE PRESIDENT OF OPERATIONS

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-90,279	-53,777	0	0	1.00
2.00	Subprovider - IPF	0	32,311	81		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	Total	0	-57,968	-53,696	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: 14-0040		Period: From 05/01/2019 To 04/30/2020		Worksheet S-2 Part I Date/Time Prepared: 9/30/2020 11:54 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 695 NORTH KELLOGG STREET			PO Box:				1.00	
2.00	City: GALESBURG			State: IL		Zip Code: 61401		County: KNOX	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			GALESBURG COTTAGE HOSPITAL	140040	99914	1	07/06/1966	N
4.00	Subprovider - IPF			GALESBURG COTTAGE PSYCH	14S040	99914	4	05/01/2006	N
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						05/01/2019	04/30/2020	
21.00	Type of Control (see instructions)						4		
							1.00	2.00	
							2.00	3.00	
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	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.			112	0	0	0	476	0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0040		Period: From 05/01/2019 To 04/30/2020		Worksheet S-2 Part I Date/Time Prepared: 9/30/2020 11:54 am	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0			25.00
						Urban/Rural S	Date of Geogr		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					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.					05/01/2019	04/30/2020		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	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no 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			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.								58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
					NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
					1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 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: 14-0040

Period:
From 05/01/2019
To 04/30/2020Worksheet S-2
Part I
Date/Time Prepared:
9/30/2020 11:54 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020Worksheet S-2
Part I
Date/Time Prepared:
9/30/2020 11:54 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0040	Period: From 05/01/2019 To 04/30/2020	Worksheet S-2 Part I Date/Time Prepared: 9/30/2020 11:54 am	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	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	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				
		1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0040	Period: From 05/01/2019 To 04/30/2020	Worksheet S-2 Part I Date/Time Prepared: 9/30/2020 11:54 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.	Y		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	177,281	186,551	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	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	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	HB0776	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0040		Period: From 05/01/2019 To 04/30/2020		Worksheet S-2 Part I Date/Time Prepared: 9/30/2020 11:54 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: COMMUNITY HEALTH SYSTEMS		Contractor's Name: WISCONSIN PHYSICIAN SERVICES		Contractor's Number: 52280		141.00		
142.00	Street: 4000 MERIDIAN BOULEVARD		PO Box:				142.00		
143.00	City: FRANKLIN		State: TN		Zip Code: 37067		143.00		
							1.00		
144.00 Are provider based physicians' costs included in Worksheet A?							Y		144.00
							1.00		2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					Y		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					N		146.00	
							1.00		
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N		147.00
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N		148.00
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N		149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital			N	N	N	N		155.00
156.00	Subprovider - IPF			N	N	N	N		156.00
157.00	Subprovider - IRF			N	N	N	N		157.00
158.00	SUBPROVIDER								158.00
159.00	SNF			N	N	N	N		159.00
160.00	HOME HEALTH AGENCY			N	N	N	N		160.00
161.00	CMHC				N	N	N		161.00
							1.00		
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N		165.00
				Name	County	State	Zip Code	CBSA	FTE/Campus
				0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00
							1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y		167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						9.99		169.00
							Beginning	Ending	
							1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
							1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N		0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0040	Period: From 05/01/2019 To 04/30/2020	Worksheet S-2 Part II Date/Time Prepared: 9/30/2020 11:54 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.	N		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 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	09/16/2020	Y
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: 14-0040	Period: From 05/01/2019 To 04/30/2020	Worksheet S-2 Part II Date/Time Prepared: 9/30/2020 11:54 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
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N	33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		Y	12/31/2019
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.	LUCIE	GREENE	41.00
42.00	Enter the employer/company name of the cost report preparer.	QUORUM HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615 221-3747	LUCIE_GREENE@QUORUMHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020Worksheet S-2
Part II
Date/Time Prepared:
9/30/2020 11:54 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.	DIRECTOR, REIMBURSEMENT	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part I
Date/Time Prepared:
9/30/2020 11:54 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	84	30,744	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)		84	30,744	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,392	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		96	35,136	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	16	5,856		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	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)		112			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: 14-0040

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part I
Date/Time Prepared:
9/30/2020 11:54 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)	1,737	86	3,451			1.00
2.00	HMO and other (see instructions)	1,173	476				2.00
3.00	HMO IPF Subprovider	948	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,737	86	3,451			7.00
8.00	INTENSIVE CARE UNIT	325	26	667			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		0	0			13.00
14.00	Total (see instructions)	2,062	112	4,118	0.00	201.66	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,572	0	4,011	0.00	26.15	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	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	227.81	27.00
28.00	Observation Bed Days		0	660			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: 14-0040

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part I
Date/Time Prepared:
9/30/2020 11:54 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	619	37	1,188	1.00
2.00 HMO and other (see instructions)			241	150		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	619	37	1,188	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	125	1	207	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						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: 14-0040

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part II
Date/Time Prepared:
9/30/2020 11:54 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	14,243,009	0	14,243,009	473,845.00	30.06
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		1,603,278	20,106	1,623,384	58,159.00	27.91
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,886,212	0	1,886,212	33,643.00	56.07
12.00	Contract labor: Top level management and other management and administrative services		102,000	0	102,000	1,360.00	75.00
13.00	Contract labor: Physician-Part A - Administrative		101,343	0	101,343	848.00	119.51
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		936,926	0	936,926	14,479.00	64.71
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)		3,189,705	0	3,189,705		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		442,373	0	442,373		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part II
Date/Time Prepared:
9/30/2020 11:54 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	148,042	0	148,042	3,929.00	37.68	26.00
27.00	Administrative & General	5.00	1,711,696	-172,695	1,539,001	56,655.00	27.16	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	472,812	0	472,812	15,928.00	29.68	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	449,565	0	449,565	29,260.00	15.36	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,188,256	82,643	1,270,899	31,647.00	40.16	38.00
39.00	Central Services and Supply	14.00	83,651	0	83,651	5,441.00	15.37	39.00
40.00	Pharmacy	15.00	558,460	0	558,460	12,444.00	44.88	40.00
41.00	Medical Records & Medical Records Library	16.00	137,061	0	137,061	6,932.00	19.77	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: 14-0040

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part III
Date/Time Prepared:
9/30/2020 11:54 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)	14,243,009	0	14,243,009	473,845.00	30.06	1.00
2.00	Excluded area salaries (see instructions)	1,603,278	20,106	1,623,384	58,159.00	27.91	2.00
3.00	Subtotal salaries (line 1 minus line 2)	12,639,731	-20,106	12,619,625	415,686.00	30.36	3.00
4.00	Subtotal other wages & related costs (see inst.)	3,026,481	0	3,026,481	50,330.00	60.13	4.00
5.00	Subtotal wage-related costs (see inst.)	3,189,705	0	3,189,705	0.00	25.28	5.00
6.00	Total (sum of lines 3 thru 5)	18,855,917	-20,106	18,835,811	466,016.00	40.42	6.00
7.00	Total overhead cost (see instructions)	4,749,543	-90,052	4,659,491	162,236.00	28.72	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0040	Period: From 05/01/2019 To 04/30/2020	Worksheet S-3 Part IV Date/Time Prepared: 9/30/2020 11:54 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		214,026	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		2,140,649	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		15,464	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		8,651	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		-439	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		8,804	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		142,022	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		830,278	17.00
18.00	Medicare Taxes - Employers Portion Only		194,178	18.00
19.00	Unemployment Insurance		0	19.00
20.00	State or Federal Unemployment Taxes		78,473	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		3,632,106	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: 14-0040

 Period:
 From 05/01/2019
 To 04/30/2020

 Worksheet S-3
 Part V
 Date/Time Prepared:
 9/30/2020 11:54 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	1,886,212	3,632,106	1.00
2.00	Hospital	1,886,212	3,632,106	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0040	Period: From 05/01/2019 To 04/30/2020	Worksheet S-10 Date/Time Prepared: 9/30/2020 11:54 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)			0.131530 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			2,818,590 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	2,120,979		5.00
6.00	Medicaid charges	65,891,149		6.00
7.00	Medicaid cost (line 1 times line 6)	8,666,663		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)	3,727,094		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	0		9.00
10.00	Stand-alone CHIP charges	0		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0		12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care	0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,727,094		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,902,931	0	1,902,931 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	250,293	0	250,293 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	250,293	0	250,293 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,358,457		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	241,270		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	371,185		27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,987,272		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	522,831		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	773,124		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,500,218		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020

Worksheet A

Date/Time Prepared:
9/30/2020 11:54 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		1,351,321	1,351,321	863,065	2,214,386 1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,407,987	1,407,987	755,667	2,163,654 2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	148,042	80,293	228,335	2,525,838	2,754,173 4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,711,696	13,645,944	15,357,640	-3,734,753	11,622,887 5.00
7.00	00700	OPERATION OF PLANT	472,812	2,805,023	3,277,835	-79,969	3,197,866 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	103,314	103,314	0	103,314 8.00
9.00	00900	HOUSEKEEPING	449,565	225,904	675,469	0	675,469 9.00
10.00	01000	DIETARY	0	1,037,085	1,037,085	-753,749	283,336 10.00
11.00	01100	CAFETERIA	0	0	0	753,749	753,749 11.00
13.00	01300	NURSING ADMINISTRATION	1,188,256	140,799	1,329,055	101,932	1,430,987 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	83,651	2,348,130	2,431,781	-2,055,791	375,990 14.00
15.00	01500	PHARMACY	558,460	1,010,984	1,569,444	-844,529	724,915 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	137,061	190,977	328,038	-3,861	324,177 16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,888,107	1,102,516	2,990,623	-1,987	2,988,636 30.00
31.00	03100	INTENSIVE CARE UNIT	1,040,414	246,580	1,286,994	-1,345	1,285,649 31.00
40.00	04000	SUBPROVIDER - IPF	1,507,874	522,223	2,030,097	-3,570	2,026,527 40.00
43.00	04300	NURSERY	0	0	0	0	0 43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,002,418	469,437	1,471,855	210,994	1,682,849 50.00
51.00	05100	RECOVERY ROOM	249,368	27,658	277,026	-277,026	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0	1,762,325	1,762,325	0	1,762,325 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	693,000	735,944	1,428,944	738,112	2,167,056 54.00
54.01	05401	ULTRASOUND	69,765	104,780	174,545	-174,545	0 54.01
56.00	05600	RADIOISOTOPE	53,011	319,955	372,966	-372,966	0 56.00
57.00	05700	CT SCAN	36,229	230,905	267,134	-267,134	0 57.00
58.00	05800	MRI	71,637	154,395	226,032	-226,032	0 58.00
60.00	06000	LABORATORY	922,648	1,249,546	2,172,194	-65,528	2,106,666 60.00
65.00	06500	RESPIRATORY THERAPY	329,211	103,158	432,369	62,851	495,220 65.00
66.00	06600	PHYSICAL THERAPY	0	343,277	343,277	220,986	564,263 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	108,148	108,148	-108,148	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	112,838	112,838	-112,838	0 68.00
69.00	06900	ELECTROCARDIOLOGY	317,112	310,926	628,038	-17,438	610,600 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	721,284	721,284 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,311,386	1,311,386 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	687,706	687,706 73.00
74.00	07400	RENAL DIALYSIS	0	184,747	184,747	0	184,747 74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0 76.00
76.01	03610	SLEEP LAB	60,096	4,691	64,787	-64,787	0 76.01
76.03	03950	WOUND CARE	112,839	619,606	732,445	-505	731,940 76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	1,044,333	1,287,591	2,331,924	1,919,690	4,251,614 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	69,946	1,855,302	1,925,248	-1,925,248	0 95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,217,551	36,204,309	50,421,860	-218,489	50,203,371 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	25,458	4,692	30,150	0	30,150 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	-3,027	-3,027	0	-3,027 192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.00
194.01	07951	MARKETING	0	0	0	218,489	218,489 194.01
194.02	07952	SENIOR CIRCLE	0	1,318	1,318	0	1,318 194.02
194.03	07953	UNUSED SPACE	0	0	0	0	0 194.03
194.04	07954	GUEST MEALS	0	0	0	0	0 194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	14,243,009	36,207,292	50,450,301	0	50,450,301 200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020

Worksheet A

Date/Time Prepared:
9/30/2020 11:54 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	-72,976	2,141,410	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-92,140	2,071,514	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-6,015	2,748,158	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,856,569	7,766,318	5.00
7.00	00700	OPERATION OF PLANT	-19,480	3,178,386	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	103,314	8.00
9.00	00900	HOUSEKEEPING	0	675,469	9.00
10.00	01000	DIETARY	0	283,336	10.00
11.00	01100	CAFETERIA	0	753,749	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,430,987	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	375,990	14.00
15.00	01500	PHARMACY	0	724,915	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-124	324,053	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-645,432	2,343,204	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,285,649	31.00
40.00	04000	SUBPROVIDER - IPF	-302,564	1,723,963	40.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,682,849	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-1,717,179	45,146	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,167,056	54.00
54.01	05401	ULTRASOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	-90,000	2,016,666	60.00
65.00	06500	RESPIRATORY THERAPY	0	495,220	65.00
66.00	06600	PHYSICAL THERAPY	0	564,263	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	610,600	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	721,284	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,311,386	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-70	687,636	73.00
74.00	07400	RENAL DIALYSIS	0	184,747	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	76.00
76.01	03610	SLEEP LAB	0	0	76.01
76.03	03950	WOUND CARE	-1,200	730,740	76.03
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-2,528,874	1,722,740	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-9,332,623	40,870,748	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	30,150	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	-3,027	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	07951	MARKETING	0	218,489	194.01
194.02	07952	SENIOR CIRCLE	0	1,318	194.02
194.03	07953	UNUSED SPACE	0	0	194.03
194.04	07954	GUEST MEALS	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-9,332,623	41,117,678	200.00

RECLASSIFICATIONS

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020

Worksheet A-6

Date/Time Prepared:
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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,526,530		1.00
	0		0	2,526,530		
	B - OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	123,042		1.00
	0		0	123,042		
	C - RENTAL AND LEASE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	752,327		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
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
	0		0	752,327		
	D - OTHER CAP COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	126,567		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	736,498		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,340		3.00
	0		0	866,405		
	E - MARKETING DEPT					
1.00	MARKETING	194.01	90,052	128,437		1.00
	0		90,052	128,437		
	F - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	598,242		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,311,386		2.00
	0		0	1,909,628		
	G - COST OF DRUGS/IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	687,706		1.00
	0		0	687,706		
	I - THERAPY COSTS					
1.00	PHYSICAL THERAPY	66.00	0	220,986		1.00
2.00		0.00	0	0		2.00
	0		0	220,986		
	J - MISCELLANEOUS DEPTS					
1.00	NURSING ADMINISTRATION	13.00	82,643	24,477		1.00
2.00	OPERATING ROOM	50.00	249,368	26,945		2.00
3.00	RESPIRATORY THERAPY	65.00	60,096	4,691		3.00
4.00	EMERGENCY	91.00	69,946	1,855,302		4.00
	0		462,053	1,911,415		
	K - OTHER RADIOLOGY COSTS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	230,642	663,752		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
	0		230,642	663,752		
	L - DIETARY TO CAFETERIA					
1.00	CAFETERIA	11.00	0	753,749		1.00
	0		0	753,749		
500.00	Grand Total: Increases		782,747	10,543,977		500.00

RECLASSIFICATIONS

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020

Worksheet A-6

Date/Time Prepared:
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	Decreases						9/30/2020 11:54 am
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,526,530	0		1.00
	0		0	2,526,530			
	B - OXYGEN COSTS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	123,042	0		1.00
	0		0	123,042			
	C - RENTAL AND LEASE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	692	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	16,209	0		2.00
3.00	OPERATION OF PLANT	7.00	0	79,969	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	5,188	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	23,121	0		5.00
6.00	PHARMACY	15.00	0	156,823	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	3,861	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	1,987	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	1,345	0		9.00
10.00	SUBPROVIDER - IPF	40.00	0	3,570	0		10.00
11.00	OPERATING ROOM	50.00	0	65,319	0		11.00
12.00	RECOVERY ROOM	51.00	0	713	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	156,282	0		13.00
14.00	CT SCAN	57.00	0	145,591	0		14.00
15.00	MRI	58.00	0	692	0		15.00
16.00	LABORATORY	60.00	0	65,528	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	1,936	0		17.00
18.00	ELECTROCARDIOLOGY	69.00	0	17,438	0		18.00
19.00	WOUND CARE	76.03	0	505	0		19.00
20.00	EMERGENCY	91.00	0	5,558	0		20.00
	0		0	752,327			
	D - OTHER CAP COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	866,405	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	0		0	866,405			
	E - MARKETING DEPT						
1.00	ADMINISTRATIVE & GENERAL	5.00	90,052	128,437	0		1.00
	0		90,052	128,437			
	F - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,909,628	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	1,909,628			
	G - COST OF DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	687,706	0		1.00
	0		0	687,706			
	I - THERAPY COSTS						
1.00	OCCUPATIONAL THERAPY	67.00	0	108,148	0		1.00
2.00	SPEECH PATHOLOGY	68.00	0	112,838	0		2.00
	0		0	220,986			
	J - MISCELLANEOUS DEPTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	82,643	24,477	0		1.00
2.00	RECOVERY ROOM	51.00	249,368	26,945	0		2.00
3.00	SLEEP LAB	76.01	60,096	4,691	0		3.00
4.00	AMBULANCE SERVICES	95.00	69,946	1,855,302	0		4.00
	0		462,053	1,911,415			
	K - OTHER RADIOLOGY COSTS						
1.00	ULTRASOUND	54.01	69,765	104,780	0		1.00
2.00	RADIOISOTOPE	56.00	53,011	319,955	0		2.00
3.00	CT SCAN	57.00	36,229	85,314	0		3.00
4.00	MRI	58.00	71,637	153,703	0		4.00
	0		230,642	663,752			
	L - DIETARY TO CAFETERIA						
1.00	DIETARY	10.00	0	753,749	0		1.00
	0		0	753,749			
500.00	Grand Total: Decreases		782,747	10,543,977			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020Worksheet A-7
Part I
Date/Time Prepared:
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		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	15,225	0	0	0	0	1.00	
2.00	Land Improvements	132,464	0	0	0	0	2.00	
3.00	Buildings and Fixtures	5,925,860	14,112	0	14,112	0	3.00	
4.00	Building Improvements	15,186,597	236,942	0	236,942	61,435	4.00	
5.00	Fixed Equipment	4,270,079	180,908	0	180,908	0	5.00	
6.00	Movable Equipment	16,996,839	532,727	0	532,727	301,639	6.00	
7.00	HIT designated Assets	4,723,939	103,258	0	103,258	3,241	7.00	
8.00	Subtotal (sum of lines 1-7)	47,251,003	1,067,947	0	1,067,947	366,315	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	47,251,003	1,067,947	0	1,067,947	366,315	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	15,225	0				1.00	
2.00	Land Improvements	132,464	0				2.00	
3.00	Buildings and Fixtures	5,939,972	0				3.00	
4.00	Building Improvements	15,362,104	0				4.00	
5.00	Fixed Equipment	4,450,987	0				5.00	
6.00	Movable Equipment	17,227,927	0				6.00	
7.00	HIT designated Assets	4,823,956	0				7.00	
8.00	Subtotal (sum of lines 1-7)	47,952,635	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	47,952,635	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020Worksheet A-7
Part II
Date/Time Prepared:
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Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,351,321	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,407,987	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,759,308	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,351,321				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,407,987				2.00
3.00	Total (sum of lines 1-2)	0	2,759,308				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020Worksheet A-7
Part III
Date/Time Prepared:
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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	21,449,766	0	21,449,766	0.447312	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	26,502,870	0	26,502,870	0.552688	0	2.00
3.00	Total (sum of lines 1-2)	47,952,636	0	47,952,636	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,175,665	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,315,847	752,327	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,491,512	752,327	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	126,567	736,498	102,680	2,141,410	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,340	0	0	2,071,514	2.00
3.00	Total (sum of lines 1-2)	0	129,907	736,498	102,680	4,212,924	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020

Worksheet A-8

Date/Time Prepared:
9/30/2020 11:54 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)	A	-25,164	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-9,233	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,285,249			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	0	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	257,187			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	0	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others	B	-7,338	CAP REL COSTS-BLDG & FIXT	1.00	14	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	B	-70	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-124	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	B	-11,462	ADMINISTRATIVE & GENERAL	5.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-376,487	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-95,484	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	LOBBYING EXPENSES	A	-8,643	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020

Worksheet A-8

Date/Time Prepared:
9/30/2020 11:54 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	
36.00	OTHER MISCELLANEOUS REVENUE	B	3,132	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	DEPRECIATION - ADMIN AND GENERAL	A	-76,795	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	PATIENT PHONE WAGE COST	A	-23,617	ADMINISTRATIVE & GENERAL	5.00	0	38.00
40.00	PATIENT PHONES BENEFITS COST	A	-6,015	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.00
41.00	PATIENT PHONES DEPRECIATION COST	A	-14,335	CAP REL COSTS-MVBLE EQUIP	2.00	9	41.00
42.00	PATIENT TV CABLE EXPENSE	A	-19,480	OPERATION OF PLANT	7.00	0	42.00
43.00	MARKETING EXP - EXCL MARKETING DEPT	A	-93,229	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00	ILLINOIS PROVIDER TAX	A	-3,644,779	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00	PHYSICIAN RECRUITING	A	-877	ADMINISTRATIVE & GENERAL	5.00	0	45.00
46.00	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-4,529	ADMINISTRATIVE & GENERAL	5.00	0	46.00
47.00	CHARITABLE CONTRIBUTIONS	A	-50	ADMINISTRATIVE & GENERAL	5.00	0	47.00
48.00	OTHER ADJUSTMENTS (SPECIFY) (3)	B	0		0.00	0	48.00
49.00	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0	49.00
49.01	MINORITY INTEREST	A	110,018	CAP REL COSTS-BLDG & FIXT	1.00	14	49.01
49.02	NONALLOWABLE LEGAL FEES	A	0		0.00	0	49.02
49.03	TELEPHONE COMMISSIONS	B	0		0.00	0	49.03
49.04	HELATHY WOMEN SPONSORSHIP	B	0		0.00	0	49.04
49.06	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0	49.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-9,332,623				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: 14-0040

Period:
From 05/01/2019
To 04/30/2020

Worksheet A-8-1

Date/Time Prepared:
9/30/2020 11:54 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		5.00	ADMINISTRATIVE & GENERAL	DIRECT ALLOCATION - QHR COST	10,775	0
2.00		5.00	ADMINISTRATIVE & GENERAL	POOLED ALLOCATION OF NON-CAP	378,060	0
3.00		1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	200,831	0
4.00		2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	26,912	0
4.01		5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL FUNCTIONAL ALLOC	1,227,624	0
4.02		5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE COSTS	363,832	-636,341
4.03		5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	2,587,188
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				2,208,034	1,950,847

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

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
	1.00	2.00	3.00	Name	Percentage of Ownership
	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	QUORUM HEALTH C	100.00	QHC	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020

Worksheet A-8-1

Date/Time Prepared:
9/30/2020 11:54 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	10,775	0		1.00
2.00	378,060	0		2.00
3.00	200,831	9		3.00
4.00	26,912	9		4.00
4.01	1,227,624	0		4.01
4.02	1,000,173	0		4.02
4.03	-2,587,188	0		4.03
5.00	257,187			5.00

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

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

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

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

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

6.00	HOSPITAL CORP		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: 14-0040

Period:
From 05/01/2019
To 04/30/2020

Worksheet A-8-2

Date/Time Prepared:
9/30/2020 11:54 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	13.00	NURSING ADMINISTRATION	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	645,432	645,432	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	302,564	302,564	0	0	0	3.00
4.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	1,717,179	1,717,179	0	0	0	5.00
6.00	60.00	LABORATORY	90,000	90,000	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	7.00
8.00	76.01	SLEEP LAB	0	0	0	0	0	8.00
9.00	76.03	WOUND CARE	1,200	1,200	0	0	0	9.00
10.00	91.00	EMERGENCY	681,031	681,031	0	0	0	10.00
11.00	91.00	EMERGENCY	1,847,843	1,847,843	0	0	0	11.00
200.00			5,285,249	5,285,249	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	3.00
4.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	7.00
8.00	76.01	SLEEP LAB	0	0	0	0	0	8.00
9.00	76.03	WOUND CARE	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
11.00	91.00	EMERGENCY	0	0	0	0	0	11.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	13.00	NURSING ADMINISTRATION	0	0	0	0		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	645,432		2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	302,564		3.00
4.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	1,717,179		5.00
6.00	60.00	LABORATORY	0	0	0	90,000		6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0		7.00
8.00	76.01	SLEEP LAB	0	0	0	0		8.00
9.00	76.03	WOUND CARE	0	0	0	1,200		9.00
10.00	91.00	EMERGENCY	0	0	0	681,031		10.00
11.00	91.00	EMERGENCY	0	0	0	1,847,843		11.00
200.00			0	0	0	5,285,249		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,141,410	2,141,410			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,071,514		2,071,514		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,748,158	7,489	7,245	2,762,892	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,766,318	279,746	270,615	301,675	5.00
7.00	00700	OPERATION OF PLANT	3,178,386	635,855	615,101	92,681	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	103,314	15,853	15,336	0	8.00
9.00	00900	HOUSEKEEPING	675,469	22,777	22,033	88,124	9.00
10.00	01000	DIETARY	283,336	57,932	56,041	0	10.00
11.00	01100	CAFETERIA	753,749	28,225	27,304	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,430,987	31,471	30,444	249,122	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	375,990	62,000	59,976	16,397	14.00
15.00	01500	PHARMACY	724,915	22,851	22,105	109,469	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	324,053	63,454	61,383	26,867	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,343,204	221,113	213,896	370,104	30.00
31.00	03100	INTENSIVE CARE UNIT	1,285,649	36,118	34,939	203,942	31.00
40.00	04000	SUBPROVIDER - IPF	1,723,963	66,081	63,924	295,573	40.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,682,849	128,397	124,206	245,375	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	45,146	2,882	2,788	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,167,056	86,521	83,697	181,052	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	2,016,666	56,208	54,373	180,857	60.00
65.00	06500	RESPIRATORY THERAPY	495,220	22,171	21,447	76,312	65.00
66.00	06600	PHYSICAL THERAPY	564,263	26,589	25,721	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	610,600	55,413	53,604	62,160	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	721,284	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,311,386	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	687,636	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	184,747	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	76.01
76.03	03950	WOUND CARE	730,740	34,892	33,754	22,119	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	1,722,740	41,910	40,542	218,421	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	40,870,748	2,005,948	1,940,474	2,740,250	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	30,150	19,699	19,056	4,990	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-3,027	6,257	6,052	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	MARKETING	218,489	0	0	17,652	194.01
194.02	07952	SENIOR CIRCLE	1,318	0	0	0	194.02
194.03	07953	UNUSED SPACE	0	109,506	105,932	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	41,117,678	2,141,410	2,071,514	2,762,892	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part I
Date/Time Prepared:
9/30/2020 11:54 am

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,618,354					5.00
7.00	00700	OPERATION OF PLANT	1,199,166	5,721,189				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	35,668	74,447	244,618			8.00
9.00	00900	HOUSEKEEPING	214,377	106,959	0	1,129,739		9.00
10.00	01000	DIETARY	105,361	272,046	0	61,156	835,872	10.00
11.00	01100	CAFETERIA	214,609	132,544	0	29,796	0	11.00
13.00	01300	NURSING ADMINISTRATION	461,960	147,788	0	33,223	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	136,402	291,148	2,741	65,450	0	14.00
15.00	01500	PHARMACY	233,189	107,307	0	24,122	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	126,164	297,979	0	66,986	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	834,890	1,038,342	61,271	233,419	354,592	30.00
31.00	03100	INTENSIVE CARE UNIT	413,862	169,610	24,044	38,128	61,298	31.00
40.00	04000	SUBPROVIDER - IPF	570,028	310,313	29,889	69,758	391,298	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	578,325	602,948	31,047	135,542	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	13,476	13,536	0	3,043	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	667,825	406,298	23,964	91,335	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
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	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	612,077	263,950	1,364	59,336	0	60.00
65.00	06500	RESPIRATORY THERAPY	163,129	104,112	498	23,404	0	65.00
66.00	06600	PHYSICAL THERAPY	163,507	124,859	0	28,068	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	207,316	260,218	3,902	58,497	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	191,274	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	347,761	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	182,351	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	48,992	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	217,852	163,854	7,283	36,834	0	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	536,634	196,808	55,149	44,242	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,476,195	5,085,066	241,152	1,102,339	807,188	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19,596	92,506	0	20,795	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,461	29,380	3,466	6,605	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	62,621	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	350	0	0	0	11,395	194.02
194.03	07953	UNUSED SPACE	57,131	514,237	0	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	17,289	194.04
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	8,618,354	5,721,189	244,618	1,129,739	835,872	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part I
Date/Time Prepared:
9/30/2020 11:54 am

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,186,227					11.00
13.00	01300	NURSING ADMINISTRATION	101,970	2,486,965				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	17,565	0	1,027,669			14.00
15.00	01500	PHARMACY	40,091	0	3,433	1,287,482		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	22,325	0	1,693	0	990,904	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	198,107	690,288	31,277	0	53,279	30.00
31.00	03100	INTENSIVE CARE UNIT	103,042	380,373	5,866	0	16,695	31.00
40.00	04000	SUBPROVIDER - IPF	175,313	551,276	8,845	0	49,282	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	111,422	457,650	118,917	0	184,937	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	9,715	0	52,657	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	99,489	0	30,706	0	164,730	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
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	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	122,216	0	112,769	0	187,773	60.00
65.00	06500	RESPIRATORY THERAPY	44,716	0	11,554	0	14,589	65.00
66.00	06600	PHYSICAL THERAPY	0	0	222	0	9,955	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	32,046	0	123	0	40,913	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	222,578	0	15,226	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	414,426	0	46,928	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,287,482	21,237	73.00
74.00	07400	RENAL DIALYSIS	0	0	93	0	2,485	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	11,330	0	16,010	0	17,871	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	94,461	407,378	39,264	0	112,347	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,174,093	2,486,965	1,027,491	1,287,482	990,904	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,564	0	32	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	6,570	0	146	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	UNUSED SPACE	0	0	0	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,186,227	2,486,965	1,027,669	1,287,482	990,904	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part I
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,643,782	0	6,643,782	30.00
31.00	03100	INTENSIVE CARE UNIT	2,773,566	0	2,773,566	31.00
40.00	04000	SUBPROVIDER - IPF	4,305,543	0	4,305,543	40.00
43.00	04300	NURSERY	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,401,615	0	4,401,615	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	143,243	0	143,243	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,002,673	0	4,002,673	54.00
54.01	05401	ULTRASOUND	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MRI	0	0	0	58.00
60.00	06000	LABORATORY	3,667,589	0	3,667,589	60.00
65.00	06500	RESPIRATORY THERAPY	977,152	0	977,152	65.00
66.00	06600	PHYSICAL THERAPY	943,184	0	943,184	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,384,792	0	1,384,792	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,150,362	0	1,150,362	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,120,501	0	2,120,501	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,178,706	0	2,178,706	73.00
74.00	07400	RENAL DIALYSIS	236,317	0	236,317	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	76.01
76.03	03950	WOUND CARE	1,292,539	0	1,292,539	76.03
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,509,896	0	3,509,896	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	39,731,460	0	39,731,460	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	212,388	0	212,388	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	51,194	0	51,194	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.00
194.01	07951	MARKETING	305,478	0	305,478	194.01
194.02	07952	SENIOR CIRCLE	13,063	0	13,063	194.02
194.03	07953	UNUSED SPACE	786,806	0	786,806	194.03
194.04	07954	GUEST MEALS	17,289	0	17,289	194.04
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	41,117,678	0	41,117,678	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part II
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	7,489	7,245	14,734	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	279,746	270,615	550,361	5.00
7.00	00700	OPERATION OF PLANT	0	635,855	615,101	1,250,956	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,853	15,336	31,189	8.00
9.00	00900	HOUSEKEEPING	0	22,777	22,033	44,810	9.00
10.00	01000	DIETARY	0	57,932	56,041	113,973	10.00
11.00	01100	CAFETERIA	0	28,225	27,304	55,529	11.00
13.00	01300	NURSING ADMINISTRATION	0	31,471	30,444	61,915	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	62,000	59,976	121,976	14.00
15.00	01500	PHARMACY	0	22,851	22,105	44,956	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	63,454	61,383	124,837	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	221,113	213,896	435,009	30.00
31.00	03100	INTENSIVE CARE UNIT	0	36,118	34,939	71,057	31.00
40.00	04000	SUBPROVIDER - IPF	0	66,081	63,924	130,005	40.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	128,397	124,206	252,603	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,882	2,788	5,670	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	86,521	83,697	170,218	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	56,208	54,373	110,581	60.00
65.00	06500	RESPIRATORY THERAPY	0	22,171	21,447	43,618	65.00
66.00	06600	PHYSICAL THERAPY	0	26,589	25,721	52,310	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	55,413	53,604	109,017	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	34,892	33,754	68,646	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	41,910	40,542	82,452	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,005,948	1,940,474	3,946,422	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,699	19,056	38,755	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,257	6,052	12,309	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	194.02
194.03	07953	UNUSED SPACE	0	109,506	105,932	215,438	194.03
194.04	07954	GUEST MEALS	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,141,410	2,071,514	4,212,924	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part II
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	551,969					5.00
7.00	00700	OPERATION OF PLANT	76,801	1,328,251				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,284	17,284	50,757			8.00
9.00	00900	HOUSEKEEPING	13,730	24,832	0	83,842		9.00
10.00	01000	DIETARY	6,748	63,159	0	4,539	188,419	10.00
11.00	01100	CAFETERIA	13,745	30,772	0	2,211	0	11.00
13.00	01300	NURSING ADMINISTRATION	29,587	34,311	0	2,466	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,736	67,594	569	4,857	0	14.00
15.00	01500	PHARMACY	14,935	24,913	0	1,790	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,080	69,180	0	4,971	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	53,471	241,065	12,714	17,323	79,931	30.00
31.00	03100	INTENSIVE CARE UNIT	26,506	39,377	4,989	2,830	13,818	31.00
40.00	04000	SUBPROVIDER - IPF	36,508	72,043	6,202	5,177	88,204	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	37,039	139,982	6,442	10,059	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	863	3,143	0	226	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,771	94,328	4,972	6,778	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
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	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	39,201	61,279	283	4,404	0	60.00
65.00	06500	RESPIRATORY THERAPY	10,448	24,171	103	1,737	0	65.00
66.00	06600	PHYSICAL THERAPY	10,472	28,988	0	2,083	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	13,278	60,413	810	4,341	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,250	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,273	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,679	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	3,138	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	13,952	38,041	1,511	2,734	0	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	34,369	45,692	11,443	3,283	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	542,864	1,180,567	50,038	81,809	181,953	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,255	21,476	0	1,543	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	158	6,821	719	490	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	4,011	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	22	0	0	0	2,569	194.02
194.03	07953	UNUSED SPACE	3,659	119,387	0	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	3,897	194.04
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)	551,969	1,328,251	50,757	83,842	188,419	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part II
Date/Time Prepared:
9/30/2020 11:54 am

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	102,257					11.00
13.00	01300	NURSING ADMINISTRATION	8,790	138,397				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,514	0	205,333			14.00
15.00	01500	PHARMACY	3,456	0	686	91,320		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,924	0	338	0	209,473	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,078	38,414	6,249	0	11,257	30.00
31.00	03100	INTENSIVE CARE UNIT	8,883	21,167	1,172	0	3,527	31.00
40.00	04000	SUBPROVIDER - IPF	15,113	30,678	1,767	0	10,412	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,605	25,468	23,760	0	39,073	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	1,941	0	11,125	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,576	0	6,135	0	34,804	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
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	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	10,535	0	22,532	0	39,789	60.00
65.00	06500	RESPIRATORY THERAPY	3,855	0	2,309	0	3,082	65.00
66.00	06600	PHYSICAL THERAPY	0	0	44	0	2,103	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,762	0	25	0	8,644	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	44,472	0	3,217	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	82,805	0	9,915	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	91,320	4,487	73.00
74.00	07400	RENAL DIALYSIS	0	0	19	0	525	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	977	0	3,199	0	3,776	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	8,143	22,670	7,845	0	23,737	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	101,211	138,397	205,298	91,320	209,473	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	480	0	6	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	566	0	29	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	UNUSED SPACE	0	0	0	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
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)	102,257	138,397	205,333	91,320	209,473	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part II
Date/Time Prepared:
9/30/2020 11:54 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	914,490	0	914,490	30.00
31.00	03100	INTENSIVE CARE UNIT	194,413	0	194,413	31.00
40.00	04000	SUBPROVIDER - IPF	397,685	0	397,685	40.00
43.00	04300	NURSERY	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	545,339	0	545,339	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	22,968	0	22,968	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	369,547	0	369,547	54.00
54.01	05401	ULTRASOUND	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MRI	0	0	0	58.00
60.00	06000	LABORATORY	289,568	0	289,568	60.00
65.00	06500	RESPIRATORY THERAPY	89,730	0	89,730	65.00
66.00	06600	PHYSICAL THERAPY	96,000	0	96,000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	199,621	0	199,621	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	59,939	0	59,939	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	114,993	0	114,993	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	107,486	0	107,486	73.00
74.00	07400	RENAL DIALYSIS	3,682	0	3,682	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	76.01
76.03	03950	WOUND CARE	132,954	0	132,954	76.03
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	240,798	0	240,798	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,779,213	0	3,779,213	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	63,542	0	63,542	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,497	0	20,497	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.00
194.01	07951	MARKETING	4,700	0	4,700	194.01
194.02	07952	SENIOR CIRCLE	2,591	0	2,591	194.02
194.03	07953	UNUSED SPACE	338,484	0	338,484	194.03
194.04	07954	GUEST MEALS	3,897	0	3,897	194.04
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,212,924	0	4,212,924	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020

Worksheet B-1

Date/Time Prepared:
9/30/2020 11:54 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	317,967				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		317,967			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,112	1,112	14,094,967		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	41,538	41,538	1,539,001	-8,618,354	5.00
7.00	00700	OPERATION OF PLANT	94,415	94,415	472,812	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,354	2,354	0	0	8.00
9.00	00900	HOUSEKEEPING	3,382	3,382	449,565	0	9.00
10.00	01000	DIETARY	8,602	8,602	0	0	10.00
11.00	01100	CAFETERIA	4,191	4,191	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,673	4,673	1,270,899	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,206	9,206	83,651	0	14.00
15.00	01500	PHARMACY	3,393	3,393	558,460	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,422	9,422	137,061	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	32,832	32,832	1,888,107	0	30.00
31.00	03100	INTENSIVE CARE UNIT	5,363	5,363	1,040,414	0	31.00
40.00	04000	SUBPROVIDER - IPF	9,812	9,812	1,507,874	0	40.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	19,065	19,065	1,251,786	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	428	428	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,847	12,847	923,642	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	8,346	8,346	922,648	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,292	3,292	389,307	0	65.00
66.00	06600	PHYSICAL THERAPY	3,948	3,948	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,228	8,228	317,112	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	76.01
76.03	03950	WOUND CARE	5,181	5,181	112,839	0	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	6,223	6,223	1,114,279	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	297,853	297,853	13,979,457	-8,618,354	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,925	2,925	25,458	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	929	929	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	90,052	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	194.02
194.03	07953	UNUSED SPACE	16,260	16,260	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	194.04
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)	2,141,410	2,071,514	2,762,892	8,618,354	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.734693	6.514871	0.196020	0.265186	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			14,734	551,969	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001045	0.016984	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020

Worksheet B-1

Date/Time Prepared:
9/30/2020 11:54 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020

Worksheet B-1

Date/Time Prepared:
9/30/2020 11:54 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	180,902				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,354	279,879			8.00
9.00	00900	HOUSEKEEPING	3,382	0	158,906		9.00
10.00	01000	DIETARY	8,602	0	8,602	25,527	10.00
11.00	01100	CAFETERIA	4,191	0	4,191	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,673	0	4,673	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,206	3,136	9,206	0	14.00
15.00	01500	PHARMACY	3,393	0	3,393	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,422	0	9,422	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	32,832	70,102	32,832	10,829	30.00
31.00	03100	INTENSIVE CARE UNIT	5,363	27,510	5,363	1,872	31.00
40.00	04000	SUBPROVIDER - IPF	9,812	34,197	9,812	11,950	40.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	19,065	35,522	19,065	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	428	0	428	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,847	27,418	12,847	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	8,346	1,561	8,346	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,292	570	3,292	0	65.00
66.00	06600	PHYSICAL THERAPY	3,948	0	3,948	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,228	4,465	8,228	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	76.01
76.03	03950	WOUND CARE	5,181	8,333	5,181	0	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	6,223	63,099	6,223	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	160,788	275,913	155,052	24,651	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,925	0	2,925	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	929	3,966	929	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	348	194.02
194.03	07953	UNUSED SPACE	16,260	0	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	528	194.04
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)	5,721,189	244,618	1,129,739	835,872	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	31.625902	0.874013	7.109480	32.744623	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,328,251	50,757	83,842	188,419	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.342379	0.181353	0.527620	7.381165	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: 14-0040

Period:
From 05/01/2019
To 04/30/2020

Worksheet B-1

Date/Time Prepared:
9/30/2020 11:54 am

Cost Center Description			NURSING ADMINISTRATION (NURSING WA GES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	
			13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	6,802,460				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,279,281			14.00
15.00	01500	PHARMACY	0	10,956	698,663		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,403	0	302,070,452	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,888,107	99,806	0	16,243,482	30.00
31.00	03100	INTENSIVE CARE UNIT	1,040,414	18,717	0	5,089,843	31.00
40.00	04000	SUBPROVIDER - IPF	1,507,874	28,225	0	15,024,857	40.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,251,786	379,464	0	56,383,082	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	30,999	0	16,053,954	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	97,982	0	50,222,489	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	359,846	0	57,213,732	60.00
65.00	06500	RESPIRATORY THERAPY	0	36,869	0	4,447,749	65.00
66.00	06600	PHYSICAL THERAPY	0	708	0	3,035,192	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	394	0	12,473,562	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	710,245	0	4,641,935	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,322,424	0	14,307,181	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	698,663	6,474,825	73.00
74.00	07400	RENAL DIALYSIS	0	296	0	757,770	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	51,087	0	5,448,625	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	1,114,279	125,290	0	34,252,174	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,802,460	3,278,711	698,663	302,070,452	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	103	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	MARKETING	0	467	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	194.02
194.03	07953	UNUSED SPACE	0	0	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	194.04
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)	2,486,965	1,027,669	1,287,482	990,904	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.365598	0.313382	1.842780	0.003280	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	138,397	205,333	91,320	209,473	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.020345	0.062615	0.130707	0.000693	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: 14-0040

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part I
Date/Time Prepared:
9/30/2020 11:54 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,643,782		6,643,782	0	6,643,782	30.00
31.00	03100	INTENSIVE CARE UNIT	2,773,566		2,773,566	0	2,773,566	31.00
40.00	04000	SUBPROVIDER - IPF	4,305,543		4,305,543	0	4,305,543	40.00
43.00	04300	NURSERY	0		0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,401,615		4,401,615	0	4,401,615	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	143,243		143,243	0	143,243	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,002,673		4,002,673	0	4,002,673	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	3,667,589		3,667,589	0	3,667,589	60.00
65.00	06500	RESPIRATORY THERAPY	977,152	0	977,152	0	977,152	65.00
66.00	06600	PHYSICAL THERAPY	943,184	0	943,184	0	943,184	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,384,792		1,384,792	0	1,384,792	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,150,362		1,150,362	0	1,150,362	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,120,501		2,120,501	0	2,120,501	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,178,706		2,178,706	0	2,178,706	73.00
74.00	07400	RENAL DIALYSIS	236,317		236,317	0	236,317	74.00
76.00	03560	OTHER ANCILLARY COSTS	0		0	0	0	76.00
76.01	03610	SLEEP LAB	0		0	0	0	76.01
76.03	03950	WOUND CARE	1,292,539		1,292,539	0	1,292,539	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	3,509,896		3,509,896	0	3,509,896	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,066,626		1,066,626	0	1,066,626	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	40,798,086	0	40,798,086	0	40,798,086	200.00
201.00		Less Observation Beds	1,066,626		1,066,626	0	1,066,626	201.00
202.00		Total (see instructions)	39,731,460	0	39,731,460	0	39,731,460	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part I
Date/Time Prepared:
9/30/2020 11:54 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						9.00	10.00	
30.00	03000	ADULTS & PEDIATRICS	12,964,931		12,964,931			30.00
31.00	03100	INTENSIVE CARE UNIT	5,089,843		5,089,843			31.00
40.00	04000	SUBPROVIDER - IPF	15,024,857		15,024,857			40.00
43.00	04300	NURSERY	0		0			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,501,277	44,881,805	56,383,082	0.078066	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	3,908,617	12,145,337	16,053,954	0.008923	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,076,462	42,146,027	50,222,489	0.079699	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
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	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	13,548,209	43,665,523	57,213,732	0.064103	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,671,866	1,775,883	4,447,749	0.219696	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,716,691	318,501	3,035,192	0.310749	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,870,462	9,603,100	12,473,562	0.111018	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,709,260	1,932,675	4,641,935	0.247819	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,917,610	8,389,571	14,307,181	0.148212	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,331,106	3,143,719	6,474,825	0.336489	0.000000	73.00
74.00	07400	RENAL DIALYSIS	707,424	50,346	757,770	0.311858	0.000000	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.03	03950	WOUND CARE	12,288	5,436,337	5,448,625	0.237223	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	4,958,403	29,293,771	34,252,174	0.102472	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	792,461	2,486,090	3,278,551	0.325335	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	96,801,767	205,268,685	302,070,452			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	96,801,767	205,268,685	302,070,452			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0040	Period: From 05/01/2019 To 04/30/2020	Worksheet C Part I Date/Time Prepared: 9/30/2020 11:54 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
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.078066		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.008923		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.079699		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.064103		60.00
65.00	06500	RESPIRATORY THERAPY	0.219696		65.00
66.00	06600	PHYSICAL THERAPY	0.310749		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.111018		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.247819		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.148212		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.336489		73.00
74.00	07400	RENAL DIALYSIS	0.311858		74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000		76.00
76.01	03610	SLEEP LAB	0.000000		76.01
76.03	03950	WOUND CARE	0.237223		76.03
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.102472		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.325335		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

Worksheet C
Part I
Date/Time Prepared:
9/30/2020 11:54 am

MCRIF32 - 16.3.168.1

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part I
Date/Time Prepared:
9/30/2020 11:54 am

			Title XIX			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	12,964,931		12,964,931			30.00
31.00	03100	INTENSIVE CARE UNIT	5,089,843		5,089,843			31.00
40.00	04000	SUBPROVIDER - IPF	15,024,857		15,024,857			40.00
43.00	04300	NURSERY	0		0			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	11,501,277	44,881,805	56,383,082	0.078066	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	3,908,617	12,145,337	16,053,954	0.008923	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,076,462	42,146,027	50,222,489	0.079699	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
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	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	13,548,209	43,665,523	57,213,732	0.064103	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,671,866	1,775,883	4,447,749	0.219696	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,716,691	318,501	3,035,192	0.310749	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,870,462	9,603,100	12,473,562	0.111018	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,709,260	1,932,675	4,641,935	0.247819	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,917,610	8,389,571	14,307,181	0.148212	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,331,106	3,143,719	6,474,825	0.336489	0.000000	73.00
74.00	07400	RENAL DIALYSIS	707,424	50,346	757,770	0.311858	0.000000	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.03	03950	WOUND CARE	12,288	5,436,337	5,448,625	0.237223	0.000000	76.03
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	4,958,403	29,293,771	34,252,174	0.102472	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	792,461	2,486,090	3,278,551	0.325335	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	96,801,767	205,268,685	302,070,452			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	96,801,767	205,268,685	302,070,452			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0040	Period: From 05/01/2019 To 04/30/2020	Worksheet C Part I Date/Time Prepared: 9/30/2020 11:54 am
			Title XIX	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
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.078066		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.008923		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.079699		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.064103		60.00
65.00	06500	RESPIRATORY THERAPY	0.219696		65.00
66.00	06600	PHYSICAL THERAPY	0.310749		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.111018		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.247819		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.148212		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.336489		73.00
74.00	07400	RENAL DIALYSIS	0.311858		74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000		76.00
76.01	03610	SLEEP LAB	0.000000		76.01
76.03	03950	WOUND CARE	0.237223		76.03
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.102472		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.325335		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part II
Date/Time Prepared:
9/30/2020 11:54 am

Cost Center Description			Title XIX		Hospital	PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,401,615	545,339	3,856,276	0	0
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	143,243	22,968	120,275	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,002,673	369,547	3,633,126	0	0
54.01	05401	ULTRASOUND	0	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MRI	0	0	0	0	0
60.00	06000	LABORATORY	3,667,589	289,568	3,378,021	0	0
65.00	06500	RESPIRATORY THERAPY	977,152	89,730	887,422	0	0
66.00	06600	PHYSICAL THERAPY	943,184	96,000	847,184	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	1,384,792	199,621	1,185,171	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,150,362	59,939	1,090,423	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,120,501	114,993	2,005,508	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	2,178,706	107,486	2,071,220	0	0
74.00	07400	RENAL DIALYSIS	236,317	3,682	232,635	0	0
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0
76.01	03610	SLEEP LAB	0	0	0	0	0
76.03	03950	WOUND CARE	1,292,539	132,954	1,159,585	0	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	3,509,896	240,798	3,269,098	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,066,626	146,817	919,809	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
200.00		Subtotal (sum of lines 50 thru 199)	27,075,195	2,419,442	24,655,753	0	0
201.00		Less Observation Beds	1,066,626	146,817	919,809	0	0
202.00		Total (line 200 minus line 201)	26,008,569	2,272,625	23,735,944	0	0

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part II
Date/Time Prepared:
9/30/2020 11:54 am

Cost Center Description			Title XIX		Hospital	PPS
			Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,401,615	56,383,082	0.078066	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	143,243	16,053,954	0.008923	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,002,673	50,222,489	0.079699	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0.000000	58.00
60.00	06000	LABORATORY	3,667,589	57,213,732	0.064103	60.00
65.00	06500	RESPIRATORY THERAPY	977,152	4,447,749	0.219696	65.00
66.00	06600	PHYSICAL THERAPY	943,184	3,035,192	0.310749	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,384,792	12,473,562	0.111018	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,150,362	4,641,935	0.247819	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,120,501	14,307,181	0.148212	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,178,706	6,474,825	0.336489	73.00
74.00	07400	RENAL DIALYSIS	236,317	757,770	0.311858	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	76.01
76.03	03950	WOUND CARE	1,292,539	5,448,625	0.237223	76.03
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,509,896	34,252,174	0.102472	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,066,626	3,278,551	0.325335	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0.000000	95.00
200.00		Subtotal (sum of lines 50 thru 199)	27,075,195	268,990,821		200.00
201.00		Less Observation Beds	1,066,626	0		201.00
202.00		Total (line 200 minus line 201)	26,008,569	268,990,821		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part I
Date/Time Prepared:
9/30/2020 11:54 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	914,490	0	914,490	4,111	222.45	30.00	
31.00	INTENSIVE CARE UNIT	194,413		194,413	667	291.47	31.00	
40.00	SUBPROVIDER - IPF	397,685	0	397,685	4,011	99.15	40.00	
43.00	NURSERY	0		0	0	0.00	43.00	
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00	
200.00	Total (lines 30 through 199)	1,506,588		1,506,588	8,789		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	1,737	386,396					30.00
31.00	INTENSIVE CARE UNIT	325	94,728					31.00
40.00	SUBPROVIDER - IPF	2,572	255,014					40.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	0	0					44.00
200.00	Total (lines 30 through 199)	4,634	736,138					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part II
Date/Time Prepared:
9/30/2020 11:54 am

			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	545,339	56,383,082	0.009672	5,588,380	54,051	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	22,968	16,053,954	0.001431	1,902,499	2,722	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	369,547	50,222,489	0.007358	3,890,716	28,628	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	289,568	57,213,732	0.005061	5,866,938	29,693	60.00
65.00	06500	RESPIRATORY THERAPY	89,730	4,447,749	0.020174	1,275,354	25,729	65.00
66.00	06600	PHYSICAL THERAPY	96,000	3,035,192	0.031629	1,094,146	34,607	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	199,621	12,473,562	0.016004	1,480,498	23,694	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	59,939	4,641,935	0.012913	1,365,454	17,632	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	114,993	14,307,181	0.008037	3,138,852	25,227	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	107,486	6,474,825	0.016601	1,112,497	18,469	73.00
74.00	07400	RENAL DIALYSIS	3,682	757,770	0.004859	391,911	1,904	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0	0	76.01
76.03	03950	WOUND CARE	132,954	5,448,625	0.024401	12,288	300	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	240,798	34,252,174	0.007030	2,475,832	17,405	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	146,817	3,278,551	0.044781	364,513	16,323	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,419,442	268,990,821		29,959,878	296,384	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0040		Period: From 05/01/2019 To 04/30/2020		Worksheet D Part III Date/Time Prepared: 9/30/2020 11:54 am		
					Title XVIII		Hospital		PPS		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost				
			1A	1.00	2A	2.00	3.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00		
43.00	04300	NURSERY	0	0	0	0	0	0	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	44.00		
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	4,111	0.00	1,737		30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	667	0.00	325		31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	4,011	0.00	2,572		40.00		
43.00	04300	NURSERY	0	0	0	0.00	0		43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0.00	0		44.00		
200.00		Total (lines 30 through 199)	0	0	8,789	0.00	4,634		200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)								
			9.00								
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0								30.00
31.00	03100	INTENSIVE CARE UNIT	0								31.00
40.00	04000	SUBPROVIDER - IPF	0								40.00
43.00	04300	NURSERY	0								43.00
44.00	04400	SKILLED NURSING FACILITY	0								44.00
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020

Worksheet D
Part IV
Date/Time Prepared:
9/30/2020 11:54 am

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
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: 14-0040

Period:
From 05/01/2019
To 04/30/2020

Worksheet D
Part IV
Date/Time Prepared:
9/30/2020 11:54 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	56,383,082	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	16,053,954	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	50,222,489	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
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	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	57,213,732	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,447,749	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,035,192	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	12,473,562	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,641,935	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,307,181	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,474,825	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	757,770	0.000000	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0.000000	76.01
76.03	03950	WOUND CARE	0	0	0	5,448,625	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	34,252,174	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,278,551	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	268,990,821		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part IV
Date/Time Prepared:
9/30/2020 11:54 am

				Title XVIII		Hospital	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	5,588,380	0	14,088,378	0	50.00	
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.000000	1,902,499	0	3,653,042	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	3,890,716	0	10,840,035	0	54.00	
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01	
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	MRI	0.000000	0	0	0	0	58.00	
60.00	06000	LABORATORY	0.000000	5,866,938	0	3,314,570	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0.000000	1,275,354	0	391,390	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	1,094,146	0	57,584	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,480,498	0	3,688,724	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,365,454	0	537,240	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	3,138,852	0	3,004,572	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,112,497	0	1,268,811	0	73.00	
74.00	07400	RENAL DIALYSIS	0.000000	391,911	0	36,710	0	74.00	
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	0	0	76.00	
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01	
76.03	03950	WOUND CARE	0.000000	12,288	0	1,801,858	0	76.03	
	OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.000000	2,475,832	0	5,065,684	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	364,513	0	730,352	0	92.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00	
200.00		Total (lines 50 through 199)		29,959,878	0	48,478,950	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part V
Date/Time Prepared:
9/30/2020 11:54 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	0.078066	14,088,378	223,966	0	1,099,823	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.008923	3,653,042	0	0	32,596	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.079699	10,840,035	0	0	863,940	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
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	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.064103	3,314,570	116	0	212,474	60.00
65.00	06500	RESPIRATORY THERAPY	0.219696	391,390	0	0	85,987	65.00
66.00	06600	PHYSICAL THERAPY	0.310749	57,584	0	0	17,894	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.111018	3,688,724	0	0	409,515	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.247819	537,240	0	0	133,138	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.148212	3,004,572	0	0	445,314	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.336489	1,268,811	7,158	0	426,941	73.00
74.00	07400	RENAL DIALYSIS	0.311858	36,710	0	0	11,448	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03950	WOUND CARE	0.237223	1,801,858	0	0	427,442	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.102472	5,065,684	0	0	519,091	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.325335	730,352	0	0	237,609	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		48,478,950	231,240	0	4,923,212	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0		201.00
		Only Charges						
202.00		Net Charges (line 200 - line 201)		48,478,950	231,240	0	4,923,212	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0040		Period: From 05/01/2019 To 04/30/2020	Worksheet D Part V Date/Time Prepared: 9/30/2020 11:54 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	17,484	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	7	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,409	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.03	03950	WOUND CARE	0	0		76.03
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	19,900	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	19,900	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0040	Period: From 05/01/2019 To 04/30/2020	Worksheet D Part II Date/Time Prepared: 9/30/2020 11:54 am		
				Component CCN: 14-S040				
				Title XVIII	Subprovider - IPF	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	545,339	56,383,082	0.009672	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	22,968	16,053,954	0.001431	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	369,547	50,222,489	0.007358	448,896	3,303	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	289,568	57,213,732	0.005061	1,533,476	7,761	60.00
65.00	06500	RESPIRATORY THERAPY	89,730	4,447,749	0.020174	199,732	4,029	65.00
66.00	06600	PHYSICAL THERAPY	96,000	3,035,192	0.031629	632,765	20,014	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	199,621	12,473,562	0.016004	109,374	1,750	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	59,939	4,641,935	0.012913	1,736	22	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	114,993	14,307,181	0.008037	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	107,486	6,474,825	0.016601	670,357	11,129	73.00
74.00	07400	RENAL DIALYSIS	3,682	757,770	0.004859	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0	0	76.01
76.03	03950	WOUND CARE	132,954	5,448,625	0.024401	0	0	76.03
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	240,798	34,252,174	0.007030	225,781	1,587	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,278,551	0.000000	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,272,625	268,990,821		3,822,117	49,595	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0040 Component CCN: 14-S040		Period: From 05/01/2019 To 04/30/2020		Worksheet D Part IV Date/Time Prepared: 9/30/2020 11:54 am	
				Title XVIII		Subprovider - IPF		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
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
54.01	05401	ULTRASOUND		0	0	0	0	0	54.01
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	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
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS		0	0	0	0	0	76.00
76.01	03610	SLEEP LAB		0	0	0	0	0	76.01
76.03	03950	WOUND CARE		0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		0		0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0040 Component CCN: 14-S040		Period: From 05/01/2019 To 04/30/2020		Worksheet D Part IV Date/Time Prepared: 9/30/2020 11:54 am	
			Title XVIII		Subprovider - IPF		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	56,383,082	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	16,053,954	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	50,222,489	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
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	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	57,213,732	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,447,749	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,035,192	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	12,473,562	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,641,935	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,307,181	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,474,825	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	757,770	0.000000	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0.000000	76.01
76.03	03950	WOUND CARE	0	0	0	5,448,625	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	34,252,174	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,278,551	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	268,990,821		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0040 Component CCN: 14-S040		Period: From 05/01/2019 To 04/30/2020		Worksheet D Part IV Date/Time Prepared: 9/30/2020 11:54 am	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	448,896	0	2,322	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
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	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	1,533,476	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	199,732	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	632,765	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	109,374	0	664	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,736	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	670,357	0	846	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03950	WOUND CARE	0.000000	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.000000	225,781	0	1,091	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		3,822,117	0	4,923	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0040

Period:

Worksheet D

Component CCN: 14-S040

From 05/01/2019
To 04/30/2020Part V
Date/Time Prepared:
9/30/2020 11:54 am

Title XVIII

Subprovider -
IPF

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	0.078066	0	0	0	0 50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.008923	0	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.079699	2,322	0	0	185 54.00
54.01	05401 ULTRASOUND	0.000000	0	0	0	0 54.01
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 MRI	0.000000	0	0	0	0 58.00
60.00	06000 LABORATORY	0.064103	0	0	0	0 60.00
65.00	06500 RESPIRATORY THERAPY	0.219696	0	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.310749	0	0	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.111018	664	0	0	74 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.247819	0	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.148212	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.336489	846	0	602	285 73.00
74.00	07400 RENAL DIALYSIS	0.311858	0	0	0	0 74.00
76.00	03560 OTHER ANCILLARY COSTS	0.000000	0	0	0	0 76.00
76.01	03610 SLEEP LAB	0.000000	0	0	0	0 76.01
76.03	03950 WOUND CARE	0.237223	0	0	0	0 76.03
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0.102472	1,091	0	0	112 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.325335	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0.000000	0	0	0	0 95.00
200.00	Subtotal (see instructions)		4,923	0	602	656 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0 201.00
202.00	Net Charges (line 200 - line 201)		4,923	0	602	656 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0040

Period:

Worksheet D

Component CCN: 14-S040

From 05/01/2019
To 04/30/2020Part V
Date/Time Prepared:
9/30/2020 11:54 am

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description			Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	ULTRASOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	203	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	76.00
76.01	03610	SLEEP LAB	0	0	76.01
76.03	03950	WOUND CARE	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	203	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	203	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part I
Date/Time Prepared:
9/30/2020 11:54 am

Cost Center Description		Title XIX		Hospital	PPS		
		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	914,490	0	914,490	4,111	222.45	30.00
31.00	INTENSIVE CARE UNIT	194,413		194,413	667	291.47	31.00
40.00	SUBPROVIDER - IPF	397,685	0	397,685	4,011	99.15	40.00
43.00	NURSERY	0		0	0	0.00	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	1,506,588		1,506,588	8,789		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	86	19,131				30.00
31.00	INTENSIVE CARE UNIT	26	7,578				31.00
40.00	SUBPROVIDER - IPF	0	0				40.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
200.00	Total (lines 30 through 199)	112	26,709				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part II
Date/Time Prepared:
9/30/2020 11:54 am

Cost Center Description		Title XIX		Hospital		PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	545,339	56,383,082	0.009672	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	22,968	16,053,954	0.001431	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	369,547	50,222,489	0.007358	0	0	54.00
54.01	05401 ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MRI	0	0	0.000000	0	0	58.00
60.00	06000 LABORATORY	289,568	57,213,732	0.005061	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	89,730	4,447,749	0.020174	0	0	65.00
66.00	06600 PHYSICAL THERAPY	96,000	3,035,192	0.031629	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	199,621	12,473,562	0.016004	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	59,939	4,641,935	0.012913	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	114,993	14,307,181	0.008037	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	107,486	6,474,825	0.016601	0	0	73.00
74.00	07400 RENAL DIALYSIS	3,682	757,770	0.004859	0	0	74.00
76.00	03560 OTHER ANCILLARY COSTS	0	0	0.000000	0	0	76.00
76.01	03610 SLEEP LAB	0	0	0.000000	0	0	76.01
76.03	03950 WOUND CARE	132,954	5,448,625	0.024401	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	240,798	34,252,174	0.007030	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	146,817	3,278,551	0.044781	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	2,419,442	268,990,821		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0040		Period: From 05/01/2019 To 04/30/2020		Worksheet D Part III Date/Time Prepared: 9/30/2020 11:54 am		
					Title XIX		Hospital		PPS		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost				
			1A	1.00	2A	2.00	3.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00		
43.00	04300	NURSERY	0	0	0	0	0	0	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	44.00		
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	4,111	0.00	86		30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	667	0.00	26		31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	4,011	0.00	0		40.00		
43.00	04300	NURSERY	0	0	0	0.00	0		43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0.00	0		44.00		
200.00		Total (lines 30 through 199)	0	0	8,789		112		200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)								
			9.00								
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0								30.00
31.00	03100	INTENSIVE CARE UNIT	0								31.00
40.00	04000	SUBPROVIDER - IPF	0								40.00
43.00	04300	NURSERY	0								43.00
44.00	04400	SKILLED NURSING FACILITY	0								44.00
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020

Worksheet D
Part IV
Date/Time Prepared:
9/30/2020 11:54 am

Cost Center Description		Title XIX			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	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
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	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
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0040		Period: From 05/01/2019 To 04/30/2020		Worksheet D Part IV Date/Time Prepared: 9/30/2020 11:54 am	
			Title XIX		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	56,383,082	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	16,053,954	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	50,222,489	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
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	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	57,213,732	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,447,749	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,035,192	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	12,473,562	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,641,935	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,307,181	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,474,825	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	757,770	0.000000	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0.000000	76.01
76.03	03950	WOUND CARE	0	0	0	5,448,625	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	34,252,174	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,278,551	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	268,990,821		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part IV
Date/Time Prepared:
9/30/2020 11:54 am

				Title XIX		Hospital	PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
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
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
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	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
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03950	WOUND CARE	0.000000	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
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
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0040	Period: From 05/01/2019 To 04/30/2020	Worksheet D-1 Date/Time Prepared: 9/30/2020 11:54 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)		4,111	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,111	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)		3,451	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)		1,737	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
	SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		6,643,782	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		6,643,782	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		6,643,782	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)		1,616.10	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,807,166	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,807,166	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020

Worksheet D-1

Date/Time Prepared:
9/30/2020 11:54 am

		Title XVIII		Hospital	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)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,773,566	667	4,158.27	325	1,351,438
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,599,341
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					7,757,945
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					481,124
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					296,384
52.00	Total Program excludable cost (sum of lines 50 and 51)					777,508
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					6,980,437
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
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
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
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
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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)					660
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,616.10
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,066,626

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020

Worksheet D-1

Date/Time Prepared:
9/30/2020 11:54 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	914,490	6,643,782	0.137646	1,066,626	146,817	90.00
91.00 Nursing School cost	0	6,643,782	0.000000	1,066,626	0	91.00
92.00 Allied health cost	0	6,643,782	0.000000	1,066,626	0	92.00
93.00 All other Medical Education	0	6,643,782	0.000000	1,066,626	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0040 Component CCN: 14-S040	Period: From 05/01/2019 To 04/30/2020	Worksheet D-1 Date/Time Prepared: 9/30/2020 11:54 am
		Title XVIII	Subprovider - IPF	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)		4,011	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,011	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)		4,011	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)		2,572	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)		4,305,543	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)		4,305,543	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)		4,305,543	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)		1,073.43	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,760,862	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,760,862	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0040	Period: From 05/01/2019 To 04/30/2020	Worksheet D-1	
				Component CCN: 14-S040		Date/Time Prepared: 9/30/2020 11:54 am	
				Title XVIII		Subprovider - IPF	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)	0	0	0.00	0		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)					635,864	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,396,726	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)					255,014	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					49,595	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					304,609	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,092,117	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: 14-0040 Component CCN: 14-S040		Period: From 05/01/2019 To 04/30/2020		Worksheet D-1 Date/Time Prepared: 9/30/2020 11:54 am	
		Title XVIII		Subprovider - IPF		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	397,685	4,305,543	0.092366	0	0	90.00
91.00	Nursing School cost	0	4,305,543	0.000000	0	0	91.00
92.00	Allied health cost	0	4,305,543	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,305,543	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0040	Period: From 05/01/2019 To 04/30/2020	Worksheet D-1 Date/Time Prepared: 9/30/2020 11:54 am
		Title XIX	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)		4,111	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,111	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)		3,451	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)		86	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		6,643,782	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		6,643,782	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		6,643,782	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)		1,616.10	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		138,985	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)		138,985	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020

Worksheet D-1

Date/Time Prepared:
9/30/2020 11:54 am

Cost Center Description		Title XIX		Hospital		PPS
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,773,566	667	4,158.27	26	108,115
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					247,100
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					26,709
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					26,709
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					220,391
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
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
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
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
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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)					660
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,616.10
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,066,626

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020

Worksheet D-1

Date/Time Prepared:
9/30/2020 11:54 am

Cost Center Description		Title XIX		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	914,490	6,643,782	0.137646	1,066,626	146,817
91.00	Nursing School cost	0	6,643,782	0.000000	1,066,626	0
92.00	Allied health cost	0	6,643,782	0.000000	1,066,626	0
93.00	All other Medical Education	0	6,643,782	0.000000	1,066,626	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0040	Period: From 05/01/2019 To 04/30/2020	Worksheet D-3 Date/Time Prepared: 9/30/2020 11:54 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		6,619,693	30.00
31.00	03100	INTENSIVE CARE UNIT		2,481,452	31.00
40.00	04000	SUBPROVIDER - IPF		86,548	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.078066	5,588,380	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.008923	1,902,499	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.079699	3,890,716	54.00
54.01	05401	ULTRASOUND	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MRI	0.000000	0	58.00
60.00	06000	LABORATORY	0.064103	5,866,938	60.00
65.00	06500	RESPIRATORY THERAPY	0.219696	1,275,354	65.00
66.00	06600	PHYSICAL THERAPY	0.310749	1,094,146	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.111018	1,480,498	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.247819	1,365,454	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.148212	3,138,852	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.336489	1,112,497	73.00
74.00	07400	RENAL DIALYSIS	0.311858	391,911	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	76.01
76.03	03950	WOUND CARE	0.237223	12,288	76.03
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.102472	2,475,832	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.325335	364,513	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		29,959,878	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		29,959,878	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0040 Component CCN: 14-S040	Period: From 05/01/2019 To 04/30/2020	Worksheet D-3 Date/Time Prepared: 9/30/2020 11:54 am	
		Title XVIII	Subprovider - IPF	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
40.00	04000 SUBPROVIDER - IPF		8,878,139		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.078066	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.008923	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.079699	448,896	35,777	54.00
54.01	05401 ULTRASOUND	0.000000	0	0	54.01
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MRI	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.064103	1,533,476	98,300	60.00
65.00	06500 RESPIRATORY THERAPY	0.219696	199,732	43,880	65.00
66.00	06600 PHYSICAL THERAPY	0.310749	632,765	196,631	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.111018	109,374	12,142	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.247819	1,736	430	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.148212	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.336489	670,357	225,568	73.00
74.00	07400 RENAL DIALYSIS	0.311858	0	0	74.00
76.00	03560 OTHER ANCILLARY COSTS	0.000000	0	0	76.00
76.01	03610 SLEEP LAB	0.000000	0	0	76.01
76.03	03950 WOUND CARE	0.237223	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.102472	225,781	23,136	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.325335	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		3,822,117	635,864	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		3,822,117		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0040	Period: From 05/01/2019 To 04/30/2020	Worksheet E Part A Date/Time Prepared: 9/30/2020 11:54 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)		1,901,509	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		2,306,010	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)		13,425	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		68,904	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)		94.20	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.11	30.00
31.00	Percentage of Medicaid patient days (see instructions)		14.28	31.00
32.00	Sum of lines 30 and 31		18.39	32.00
33.00	Allowable disproportionate share percentage (see instructions)		4.70	33.00
34.00	Disproportionate share adjustment (see instructions)		49,439	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0040	Period: From 05/01/2019 To 04/30/2020	Worksheet E Part A Date/Time Prepared: 9/30/2020 11:54 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)	343,425	270,835		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	143,956	157,617		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	301,573			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)	4,640,860			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	5,151,922			48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)		5,024,157		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		344,152		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)		5,368,309		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		5,368,309		61.00
62.00	Deductibles billed to program beneficiaries		560,076		62.00
63.00	Coinsurance billed to program beneficiaries		8,954		63.00
64.00	Allowable bad debts (see instructions)		164,733		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		107,076		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		91,363		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		4,906,355		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)		-331		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		-1,722		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		-3,805		70.93
70.94	HRR adjustment amount (see instructions)		-19,002		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0040	Period: From 05/01/2019 To 04/30/2020	Worksheet E Part A Date/Time Prepared: 9/30/2020 11:54 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)		4,881,495	71.00
71.01	Sequestration adjustment (see instructions)		97,630	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		4,874,144	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)		-90,279	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		441,212	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)		160,231	223,066
HVPB Adjustment for HSP Bonus Payment				
101.00	HVPB adjustment factor (see instructions)		0.9984404452	0.9996363764
102.00	HVPB adjustment amount for HSP bonus payment (see instructions)		-250	-81
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.9951	0.9958
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		-785	-937
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0040	Period: From 05/01/2019 To 04/30/2020	Worksheet E Part B Date/Time Prepared: 9/30/2020 11:54 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		19,900	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		4,923,212	2.00
3.00	OPPS payments		3,728,443	3.00
4.00	Outlier payment (see instructions)		1,735	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		19,900	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		231,240	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)		231,240	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)		231,240	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		211,340	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)		19,900	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)		3,730,178	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		43,891	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		725,968	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		2,980,219	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,980,219	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		2,980,219	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)		155,729	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		101,224	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		79,965	36.00
37.00	Subtotal (see instructions)		3,081,443	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)		3,081,443	40.00
40.01	Sequestration adjustment (see instructions)		61,629	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		3,073,591	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)		-53,777	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: 14-0040	Period: From 05/01/2019 To 04/30/2020	Worksheet E Part B Date/Time Prepared: 9/30/2020 11:54 am
		Component CCN: 14-S040		
		Title XVIII	Subprovider - IPF	PPS
			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		203	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		656	2.00
3.00	OPPS payments		505	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		203	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		602	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)		602	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)		602	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		399	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)		203	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)		505	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)		52	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)		656	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)		656	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		656	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)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		656	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		656	40.00
40.01	Sequestration adjustment (see instructions)		13	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		562	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)		81	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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020Worksheet E-1
Part I
Date/Time Prepared:
9/30/2020 11:54 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		4,874,144		3,073,591	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,874,144		3,073,591	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		90,279		53,777	6.02
7.00	Total Medicare program liability (see instructions)		4,783,865		3,019,814	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: 14-0040 Component CCN: 14-S040		Period: From 05/01/2019 To 04/30/2020		Worksheet E-1 Part I Date/Time Prepared: 9/30/2020 11:54 am	
		Title XVIII		Subprovider - IPF		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						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		2,410,848		562		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,410,848		562		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		32,311		81		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		2,443,159		643		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: 14-0040	Period: From 05/01/2019 To 04/30/2020	Worksheet E-1 Part II Date/Time Prepared: 9/30/2020 11:54 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0040 Component CCN: 14-S040	Period: From 05/01/2019 To 04/30/2020	Worksheet E-3 Part II Date/Time Prepared: 9/30/2020 11:54 am
		Title XVIII	Subprovider - IPF	PPS
			1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS			
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			2,581,403 1.00
2.00	Net IPF PPS Outlier Payments			8,116 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	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 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instnctions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instnctions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			10.959016 9.00
10.00	Teaching Adjustment Factor {{{1 + (line 8/line 9)) raised to the power of .5150 -1}}.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			2,589,519 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			2,589,519 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			2,589,519 18.00
19.00	Deductibles			91,960 19.00
20.00	Subtotal (line 18 minus line 19)			2,497,559 20.00
21.00	Coinsurance			37,510 21.00
22.00	Subtotal (line 20 minus line 21)			2,460,049 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			50,723 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			32,970 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			41,823 25.00
26.00	Subtotal (sum of lines 22 and 24)			2,493,019 26.00
27.00	Direct graduate medical education payments (see instructions)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			2,493,019 31.00
31.01	Sequestration adjustment (see instructions)			49,860 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			2,410,848 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			32,311 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			8,116 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: 14-0040

Period:
From 05/01/2019
To 04/30/2020

Worksheet G

Date/Time Prepared:
9/30/2020 11:54 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	-624,661	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	9,198,444	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,508,593	0	0	0	6.00
7.00	Inventory	1,452,746	0	0	0	7.00
8.00	Prepaid expenses	586,519	0	0	0	8.00
9.00	Other current assets	231,829	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)	8,336,284	0	0	0	11.00
FIXED ASSETS						
12.00	Land	259,268	0	0	0	12.00
13.00	Land improvements	554,380	0	0	0	13.00
14.00	Accumulated depreciation	-523,509	0	0	0	14.00
15.00	Buildings	15,743,951	0	0	0	15.00
16.00	Accumulated depreciation	-8,326,627	0	0	0	16.00
17.00	Leasehold improvements	15,544,410	0	0	0	17.00
18.00	Accumulated depreciation	-8,387,651	0	0	0	18.00
19.00	Fixed equipment	4,384,496	0	0	0	19.00
20.00	Accumulated depreciation	-2,730,916	0	0	0	20.00
21.00	Automobiles and trucks	30,160	0	0	0	21.00
22.00	Accumulated depreciation	-30,160	0	0	0	22.00
23.00	Major movable equipment	11,994,734	0	0	0	23.00
24.00	Accumulated depreciation	-10,660,787	0	0	0	24.00
25.00	Minor equipment depreciable	5,040,850	0	0	0	25.00
26.00	Accumulated depreciation	-4,759,440	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	18,133,159	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	2,191,760	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,191,760	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	28,661,203	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,364,810	0	0	0	37.00
38.00	Salaries, wages, and fees payable	747,224	0	0	0	38.00
39.00	Payroll taxes payable	123,074	0	0	0	39.00
40.00	Notes and loans payable (short term)	488,396	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	-10,542,532	0	0	0	43.00
44.00	Other current liabilities	2,508,413	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-4,310,615	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-4,310,615	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	32,971,818	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	0	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)	32,971,818	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	28,661,203	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020

Worksheet G-1

Date/Time Prepared:
9/30/2020 11:54 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		41,597,471		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-8,625,652				2.00
3.00	Total (sum of line 1 and line 2)		32,971,819		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		32,971,819		0		11.00
12.00	ROUNDING	1		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		1		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		32,971,818		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	ROUNDING		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
9/30/2020 11:54 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	12,964,931		12,964,931	1.00
2.00	SUBPROVIDER - IPF	15,024,857		15,024,857	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	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)	27,989,788		27,989,788	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,089,843		5,089,843	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)	5,089,843		5,089,843	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	33,079,631		33,079,631	17.00
18.00	Ancillary services	57,971,272	173,488,824	231,460,096	18.00
19.00	Outpatient services	5,750,864	31,779,861	37,530,725	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	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)	96,801,767	205,268,685	302,070,452	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		50,450,301		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)		50,450,301		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0040

Period:
From 05/01/2019
To 04/30/2020

Worksheet G-3

Date/Time Prepared:
9/30/2020 11:54 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	302,070,452	1.00
2.00	Less contractual allowances and discounts on patients' accounts	260,257,603	2.00
3.00	Net patient revenues (line 1 minus line 2)	41,812,849	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	50,450,301	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-8,637,452	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	17,432	24.00
25.00	Total other income (sum of lines 6-24)	17,432	25.00
26.00	Total (line 5 plus line 25)	-8,620,020	26.00
27.00	OTHER	5,632	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	5,632	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-8,625,652	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0040	Period: From 05/01/2019 To 04/30/2020	Worksheet L Parts I-III Date/Time Prepared: 9/30/2020 11:54 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		335,879	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		8,273	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)		11.25	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)		344,152	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