

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: 14-0043	Period: From 05/01/2019 To 04/30/2020	Worksheet S Parts I-III Date/Time Prepared: 9/29/2020 8:26 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 9/29/2020	Time: 8:26 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 CGH MEDICAL CENTER (14-0043) 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) BEN SCHAAB

Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER

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	-2,628	100,424	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	-2,628	100,424	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: 14-0043		Period: From 05/01/2019 To 04/30/2020		Worksheet S-2 Part I Date/Time Prepared: 9/29/2020 8:26 am	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 100 EAST LEFEVRE ROAD			PO Box:				1.00		
2.00	City: STERLING			State: IL		Zip Code: 61081-1279		County: WHITESIDE		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	XIX
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		CGH MEDICAL CENTER	140043	99914	1	07/01/1966	N	P	N
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		CGH MEDICAL CENTER	14U043	99914		01/13/2004	N	P	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA		CGH HOME NURSING	147562	99914		05/05/1994	N	P	N
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		20.00
21.00	Type of Control (see instructions)						12			21.00
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N		23.00	
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
				1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			487	714	10	12	1,361	98	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0043

Period:
From 05/01/2019
To 04/30/2020Worksheet S-2
Part I
Date/Time Prepared:
9/29/2020 8:26 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
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals								
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
				1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.					N		60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0043

Period:
From 05/01/2019
To 04/30/2020Worksheet S-2
Part I
Date/Time Prepared:
9/29/2020 8:26 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

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Period:
From 05/01/2019
To 04/30/2020Worksheet S-2
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
	1.00	2.00	3.00	4.00	5.00			
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
			1.00	2.00	3.00			
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		
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
	1.00	2.00	3.00	4.00	5.00			
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00		
					1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS								
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N		70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				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)				N	N	0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0043	Period: From 05/01/2019 To 04/30/2020	Worksheet S-2 Part I Date/Time Prepared: 9/29/2020 8:26 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)	N		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
		1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N			110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0043	Period: From 05/01/2019 To 04/30/2020	Worksheet S-2 Part I Date/Time Prepared: 9/29/2020 8:26 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:	1,274,754	0	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	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.	N		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)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0043		Period: From 05/01/2019 To 04/30/2020		Worksheet S-2 Part I Date/Time Prepared: 9/29/2020 8:26 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:	Contractor's Name:		Contractor's Number:				141.00		
142.00	Street:	PO Box:						142.00		
143.00	City:	State:		Zip Code:				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			166.00
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00	
						Beginning	Ending			
						1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00	
						1.00	2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N	0		171.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0043

Period:
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		Y/N	Date	
		1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	08/03/2020
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
		Y/N	Legal Oper.	
		1.00	2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
		Y/N		
		1.00		
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N	Date	Y/N
		1.00	2.00	3.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	08/03/2020	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

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Period:
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		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		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.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN		41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSENALLEN LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446	KEVIN.WELLEN@CLACONNECT.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0043

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		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		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: 14-0043

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part I
Date/Time Prepared:
9/29/2020 8:26 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	79	28,914	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)		79	28,914	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	9	3,294	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)		88	32,208	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	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)		88			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: 14-0043

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part I
Date/Time Prepared:
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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)	6,286	135	11,470			1.00
2.00	HMO and other (see instructions)	1,589	2,097				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	6,286	135	11,470			7.00
8.00	INTENSIVE CARE UNIT	809	187	1,330			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		165	918			13.00
14.00	Total (see instructions)	7,095	487	13,718	0.00	1,312.89	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	3,777	0	7,766	0.00	16.70	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	1,329.59	27.00
28.00	Observation Bed Days		0	2,960			28.00
29.00	Ambulance Trips	2,149					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	98	175			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: 14-0043

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part I
Date/Time Prepared:
9/29/2020 8:26 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,825	40	3,790	1.00
2.00 HMO and other (see instructions)			359	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,825	40	3,790	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					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: 14-0043

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part II
Date/Time Prepared:
9/29/2020 8:26 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	100,925,906	0	100,925,906	2,761,793.16	36.54
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		2,529,347	0	2,529,347	16,053.28	157.56
4.00	Physician-Part A - Administrative		169,887	0	169,887	1,132.58	150.00
4.01	Physicians - Part A - Teaching		31,331,981	0	31,331,981	197,052.00	159.00
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)		8,314,864	0	8,314,864	244,089.21	34.06
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,324,873	0	1,324,873	17,852.50	74.21
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		5,150	0	5,150	34.33	150.01
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		0	0	0	0.00	0.00
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)		25,938,866	0	25,938,866		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		3,026,368	0	3,026,368		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		354,037	0	354,037		
22.00	Physician Part A - Administrative		23,433	0	23,433		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		4,243,309	0	4,243,309		
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: 14-0043

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part II
Date/Time Prepared:
9/29/2020 8:26 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	609,646	0	609,646	14,716.48	41.43	26.00
27.00	Administrative & General	5.00	12,893,320	-593,912	12,299,408	435,173.32	28.26	27.00
28.00	Administrative & General under contract (see inst.)		339,357	0	339,357	987.30	343.72	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,388,068	0	1,388,068	52,997.09	26.19	30.00
31.00	Laundry & Linen Service	8.00	282,399	0	282,399	21,705.76	13.01	31.00
32.00	Housekeeping	9.00	1,251,897	0	1,251,897	90,597.21	13.82	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	992,867	-810,589	182,278	11,900.48	15.32	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	810,589	810,589	52,918.00	15.32	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,103,867	-766,539	337,328	8,666.28	38.92	38.00
39.00	Central Services and Supply	14.00	495,687	0	495,687	23,636.64	20.97	39.00
40.00	Pharmacy	15.00	1,484,962	-1,484,962	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	1,825,223	0	1,825,223	81,683.92	22.34	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: 14-0043

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part III
Date/Time Prepared:
9/29/2020 8:26 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)	67,403,935	0	67,403,935	2,549,675.18	26.44	1.00
2.00	Excluded area salaries (see instructions)	8,314,864	0	8,314,864	244,089.21	34.06	2.00
3.00	Subtotal salaries (line 1 minus line 2)	59,089,071	0	59,089,071	2,305,585.97	25.63	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,330,023	0	1,330,023	17,886.83	74.36	4.00
5.00	Subtotal wage-related costs (see inst.)	25,962,299	0	25,962,299	0.00	43.94	5.00
6.00	Total (sum of lines 3 thru 5)	86,381,393	0	86,381,393	2,323,472.80	37.18	6.00
7.00	Total overhead cost (see instructions)	22,667,293	-2,845,413	19,821,880	794,982.48	24.93	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0043

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part IV
Date/Time Prepared:
9/29/2020 8:26 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	3,308,595	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)	5,545,323	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)	18,164,126	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	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	199,360	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	200,046	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	-82,317	16.00
TAXES			
17.00	FICA-Employers Portion Only	4,673,963	17.00
18.00	Medicare Taxes - Employers Portion Only	1,425,622	18.00
19.00	Unemployment Insurance	34,468	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	116,827	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	33,586,013	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: 14-0043

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part V
Date/Time Prepared:
9/29/2020 8:26 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	1,324,873	33,586,013	1.00
2.00	Hospital	1,324,873	33,586,013	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	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

HOME HEALTH AGENCY STATISTICAL DATA				Provider CCN: 14-0043 Component CCN: 14-7562		Period: From 05/01/2019 To 04/30/2020		Worksheet S-4 Date/Time Prepared: 9/29/2020 8:26 am	
						Home Health Agency I		PPS	
						1.00			
0.00	County					WHITESIDE		0.00	
				Title V	Title XVIII	Title XIX	Other	Total	
				1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA									
1.00	Home Health Aide Hours			0	265	0	1,921	2,186	1.00
2.00	Unduplicated Census Count (see instructions)			0.00	263.00	45.00	239.00	547.00	2.00
				Number of Employees (Full Time Equivalent)					
				Enter the number of hours in your normal work week		Staff	Contract	Total	
				0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES									
3.00	Administrator and Assistant Administrator(s)			40.00		1.54	0.00	1.54	3.00
4.00	Director(s) and Assistant Director(s)					0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel					0.00	0.00	0.00	5.00
6.00	Direct Nursing Service					10.62	0.00	10.62	6.00
7.00	Nursing Supervisor					0.00	0.00	0.00	7.00
8.00	Physical Therapy Service					2.78	0.00	2.78	8.00
9.00	Physical Therapy Supervisor					0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service					0.57	0.00	0.57	10.00
11.00	Occupational Therapy Supervisor					0.00	0.00	0.00	11.00
12.00	Speech Pathology Service					0.14	0.00	0.14	12.00
13.00	Speech Pathology Supervisor					0.00	0.00	0.00	13.00
14.00	Medical Social Service					0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor					0.00	0.00	0.00	15.00
16.00	Home Health Aide					1.05	0.00	1.05	16.00
17.00	Home Health Aide Supervisor					0.00	0.00	0.00	17.00
18.00	Other (specify)					0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES									
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.					1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99914					20.00
				Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
				Without Outliers	With Outliers				
				1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA									
21.00	Skilled Nursing Visits			1,577	473	67	22	2,139	21.00
22.00	Skilled Nursing Visit Charges			323,609	104,266	15,181	4,180	447,236	22.00
23.00	Physical Therapy Visits			960	59	27	1	1,047	23.00
24.00	Physical Therapy Visit Charges			205,343	11,901	4,782	165	222,191	24.00
25.00	Occupational Therapy Visits			191	43	3	1	238	25.00
26.00	Occupational Therapy Visit Charges			40,423	9,568	582	166	50,739	26.00
27.00	Speech Pathology Visits			87	0	1	0	88	27.00
28.00	Speech Pathology Visit Charges			19,298	0	178	0	19,476	28.00
29.00	Medical Social Service Visits			0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges			0	0	0	0	0	30.00
31.00	Home Health Aide Visits			193	71	1	0	265	31.00
32.00	Home Health Aide Visit Charges			15,633	5,564	68	0	21,265	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)			3,008	646	99	24	3,777	33.00
34.00	Other Charges			0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)			604,306	131,299	20,791	4,511	760,907	35.00
36.00	Total Number of Episodes (standard/non outlier)			269		36	3	308	36.00
37.00	Total Number of Outlier Episodes				26		0	26	37.00
38.00	Total Non-Routine Medical Supply Charges			9,723	7,811	1,208	2,207	20,949	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0043	Period: From 05/01/2019 To 04/30/2020	Worksheet S-10 Date/Time Prepared: 9/29/2020 8:26 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)			0.227459 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			3,282,482 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	9,100,566		5.00
6.00	Medicaid charges	84,712,446		6.00
7.00	Medicaid cost (line 1 times line 6)	19,268,608		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)	6,885,560		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	167,010		9.00
10.00	Stand-alone CHIP charges	1,811,109		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	411,953		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	244,943		12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care	0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	7,130,503		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)	26,033,122	126,061	26,159,183 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	5,921,468	126,061	6,047,529 21.00
22.00	Payments received from patients for amounts previously written off as charity care	1,274,403	0	1,274,403 22.00
23.00	Cost of charity care (line 21 minus line 22)	4,647,065	126,061	4,773,126 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)	16,327,894		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	958,239		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,474,214		27.01
28.00	Non-Medicare bad debt expense (see instructions)	14,853,680		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	3,894,578		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	8,667,704		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	15,798,207		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0043

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

Worksheet A

Date/Time Prepared:
9/29/2020 8:26 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		11,275,813	11,275,813	-5,634,800	5,641,013	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	7,480,733	7,480,733	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	609,646	33,541,024	34,150,670	-1,923	34,148,747	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,893,320	13,500,707	26,394,027	-328,429	26,065,598	5.00
7.00	00700	OPERATION OF PLANT	1,388,068	2,767,349	4,155,417	60,897	4,216,314	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	282,399	128,480	410,879	0	410,879	8.00
9.00	00900	HOUSEKEEPING	1,251,897	1,289,485	2,541,382	0	2,541,382	9.00
10.00	01000	DIETARY	992,867	747,556	1,740,423	-1,427,786	312,637	10.00
11.00	01100	CAFETERIA	0	0	0	1,420,903	1,420,903	11.00
13.00	01300	NURSING ADMINISTRATION	1,103,867	207,821	1,311,688	-772,624	539,064	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	495,687	440,754	936,441	-250,084	686,357	14.00
15.00	01500	PHARMACY	1,484,962	8,023,069	9,508,031	-9,031,491	476,540	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,825,223	800,465	2,625,688	-658	2,625,030	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,355,701	1,213,219	11,568,920	-630,068	10,938,852	30.00
31.00	03100	INTENSIVE CARE UNIT	2,589,940	560,418	3,150,358	-1,068,859	2,081,499	31.00
43.00	04300	NURSERY	0	0	0	564,115	564,115	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,353,473	6,701,364	8,054,837	-5,862,954	2,191,883	50.00
51.00	05100	RECOVERY ROOM	867,034	596,665	1,463,699	-209,557	1,254,142	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,170,906	1,170,906	52.00
53.00	05300	ANESTHESIOLOGY	2,529,347	1,555,698	4,085,045	-511,007	3,574,038	53.00
53.01	05301	PAIN MANAGEMENT	979,013	73,858	1,052,871	-43,782	1,009,089	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,122,424	2,098,600	3,221,024	142,253	3,363,277	54.00
54.01	05401	ULTRASOUND	534,894	655,189	1,190,083	78,482	1,268,565	54.01
56.00	05600	RADIOISOTOPE	182,850	968,182	1,151,032	-755,225	395,807	56.00
57.00	05700	CT SCAN	539,400	2,382,863	2,922,263	-60,341	2,861,922	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	329,392	802,054	1,131,446	18,720	1,150,166	58.00
59.00	05900	CARDIAC CATHETERIZATION	686,261	2,108,532	2,794,793	-1,455,299	1,339,494	59.00
60.00	06000	LABORATORY	2,956,101	4,338,764	7,294,865	-1,890,452	5,404,413	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	904,529	356,898	1,261,427	-181,122	1,080,305	65.00
66.00	06600	PHYSICAL THERAPY	442,335	8,773	451,108	-1,458	449,650	66.00
67.00	06700	OCCUPATIONAL THERAPY	83,237	5,101	88,338	-2,428	85,910	67.00
68.00	06800	SPEECH PATHOLOGY	141,999	11,505	153,504	-1,179	152,325	68.00
69.00	06900	ELECTROCARDIOLOGY	928,975	191,988	1,120,963	-76,874	1,044,089	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	199,131	53,488	252,619	-37,971	214,648	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	14,524,406	14,524,406	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	28,957,556	28,957,556	73.00
74.00	07400	RENAL DIALYSIS	0	210,973	210,973	-1,817	209,156	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	GI LAB	1,153,011	1,016,203	2,169,214	-850,498	1,318,716	75.01
76.00	03950	DIABETIC EDUCATION	141,429	8,782	150,211	-8,019	142,192	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	681,413	660,178	1,341,591	-409,696	931,895	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	37,066,456	24,788,081	61,854,537	-20,276,414	41,578,123	90.00
91.00	09100	EMERGENCY	3,514,761	4,895,512	8,410,273	-489,417	7,920,856	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,682,975	342,978	2,025,953	-197,232	1,828,721	95.00
98.00	09850	HOME INFUSION	64,967	180,861	245,828	-26,335	219,493	98.00
101.00	10100	HOME HEALTH AGENCY	1,261,283	193,059	1,454,342	-52,790	1,401,552	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		263,303	263,303	-263,303	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	95,620,267	129,965,612	225,585,879	1,607,079	227,192,958	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	21,376	27,713	49,089	0	49,089	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,695,007	851,507	3,546,514	-33,794	3,512,720	192.00
194.00	07950	COMMUNITY SERVICE	183,169	11,392	194,561	-1,755	192,806	194.00
194.01	07951	OFFSITE FREESTANDING PT/OT	2,406,087	157,394	2,563,481	-1,118	2,562,363	194.01
194.02	07952	OFFSITE BUILDINGS	0	1,570,412	1,570,412	-1,570,412	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	100,925,906	132,584,030	233,509,936	0	233,509,936	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0043

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

Worksheet A

Date/Time Prepared:
9/29/2020 8:26 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	-263,303	5,377,710	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-32,984	7,447,749	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-4,103,779	30,044,968	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,564,858	23,500,740	5.00
7.00	00700	OPERATION OF PLANT	-820	4,215,494	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-13,023	397,856	8.00
9.00	00900	HOUSEKEEPING	-198	2,541,184	9.00
10.00	01000	DIETARY	0	312,637	10.00
11.00	01100	CAFETERIA	-759,344	661,559	11.00
13.00	01300	NURSING ADMINISTRATION	0	539,064	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	686,357	14.00
15.00	01500	PHARMACY	-3,000	473,540	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-50,722	2,574,308	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,712,326	8,226,526	30.00
31.00	03100	INTENSIVE CARE UNIT	-55,080	2,026,419	31.00
43.00	04300	NURSERY	0	564,115	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	2,191,883	50.00
51.00	05100	RECOVERY ROOM	0	1,254,142	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,170,906	52.00
53.00	05300	ANESTHESIOLOGY	-3,531,801	42,237	53.00
53.01	05301	PAIN MANAGEMENT	-756,972	252,117	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,253,578	2,109,699	54.00
54.01	05401	ULTRASOUND	-569,357	699,208	54.01
56.00	05600	RADIOISOTOPE	-67,161	328,646	56.00
57.00	05700	CT SCAN	-1,867,017	994,905	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-641,680	508,486	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,339,494	59.00
60.00	06000	LABORATORY	-584,396	4,820,017	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	-2,908	1,077,397	65.00
66.00	06600	PHYSICAL THERAPY	0	449,650	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	85,910	67.00
68.00	06800	SPEECH PATHOLOGY	0	152,325	68.00
69.00	06900	ELECTROCARDIOLOGY	-10,167	1,033,922	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-2,591	212,057	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,524,406	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-2,850,839	26,106,717	73.00
74.00	07400	RENAL DIALYSIS	0	209,156	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
75.01	07501	GI LAB	0	1,318,716	75.01
76.00	03950	DIABETIC EDUCATION	0	142,192	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	-285,532	646,363	76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-30,883,824	10,694,299	90.00
91.00	09100	EMERGENCY	-4,292,308	3,628,548	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-512	1,828,209	95.00
98.00	09850	HOME INFUSION	-1,156	218,337	98.00
101.00	10100	HOME HEALTH AGENCY	-199	1,401,353	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-58,161,435	169,031,523	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	49,089	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,512,720	192.00
194.00	07950	COMMUNITY SERVICE	0	192,806	194.00
194.01	07951	OFFSITE FREESTANDING PT/OT	0	2,562,363	194.01
194.02	07952	OFFSITE BUILDINGS	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-58,161,435	175,348,501	200.00

RECLASSIFICATIONS

Provider CCN: 14-0043

Period:
From 05/01/2019
To 04/30/2020Worksheet A-6
Date/Time Prepared:
9/29/2020 8:26 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	263,303		1.00
	0		0	263,303		
	B - L&D AND NURSERY COST					
1.00	NURSERY	43.00	499,993	36,587		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1,037,811	75,943		2.00
	0		1,537,804	112,530		
	C - OFFSITE BLDG					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	298,218		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	759,233		2.00
3.00	OTHER CAP REL COSTS	3.00	0	19,914		3.00
4.00	OPERATION OF PLANT	7.00	0	493,047		4.00
	0		0	1,570,412		
	E - COLLECTIONS & BILLING EXP					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	120,581		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
	0		0	120,581		
	F - CAFETERIA EXPENSE					
1.00	CAFETERIA	11.00	810,589	610,314		1.00
	0		810,589	610,314		
	G - DRUG EXPENSE					
1.00	DRUGS CHARGED TO PATIENTS	73.00	1,484,962	27,472,594		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
21.00		0.00	0	0		21.00
	0		1,484,962	27,472,594		
	H - MARKETING & ADVERTISING					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	30,224		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
	0		0	30,224		
	I - TELEPHONE EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	137,985		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
	0		0	137,985		

RECLASSIFICATIONS

Provider CCN: 14-0043

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

Worksheet A-6

Date/Time Prepared:
9/29/2020 8:26 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	J - PROPERTY INSURANCE & TAXES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	328,686		1.00
2.00	OTHER CAP REL COSTS	3.00	0	176,579		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
	0		0	505,265		
	K - MALPRACTICE INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	17,200		1.00
	0		0	17,200		
	L - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	14,524,406		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
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
	0		0	14,524,406		
	N - POST ICU					
1.00	ADULTS & PEDIATRICS	30.00	918,606	113,929		1.00
	0		918,606	113,929		
	O - MME DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	7,392,404		1.00
	0		0	7,392,404		
	P - UTILITIES EXPENSE					
1.00	OPERATION OF PLANT	7.00	0	7,506		1.00
	0		0	7,506		
	Q - NURSE FLOATS & SHIFT COORDINATORS					
1.00	ADULTS & PEDIATRICS	30.00	565,970	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	115,882	0		2.00
3.00	NURSERY	43.00	27,535	0		3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	57,152	0		4.00
	0		766,539	0		
	R - RADIOLOGY MANAGEMENT					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	288,335	13,979		1.00
2.00	ULTRASOUND	54.01	95,507	4,631		2.00
3.00	RADIOISOTOPE	56.00	37,541	1,820		3.00
4.00	CT SCAN	57.00	110,268	5,346		4.00
5.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	62,261	3,019		5.00
	0		593,912	28,795		
500.00	Grand Total: Increases		6,112,412	52,907,448		500.00

RECLASSIFICATIONS

Provider CCN: 14-0043

Period:
From 05/01/2019
To 04/30/2020Worksheet A-6
Date/Time Prepared:
9/29/2020 8:26 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	263,303	11		1.00
	0		0	263,303			
	B - L&D AND NURSERY COST						
1.00	ADULTS & PEDIATRICS	30.00	1,537,804	112,530	0		1.00
2.00		0.00	0	0	0		2.00
	0		1,537,804	112,530			
	C - OFFSITE BLDG						
1.00	OFFSITE BUILDINGS	194.02	0	1,570,412	13		1.00
2.00		0.00	0	0	10		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	0		0	1,570,412			
	E - COLLECTIONS & BILLING EXP						
1.00	DIETARY	10.00	0	6,883	0		1.00
2.00	PHARMACY	15.00	0	13,475	0		2.00
3.00	AMBULANCE SERVICES	95.00	0	100,199	0		3.00
4.00	HOME INFUSION	98.00	0	19	0		4.00
5.00	HOME HEALTH AGENCY	101.00	0	5	0		5.00
	0		0	120,581			
	F - CAFETERIA EXPENSE						
1.00	DIETARY	10.00	810,589	610,314	0		1.00
	0		810,589	610,314			
	G - DRUG EXPENSE						
1.00	NURSING ADMINISTRATION	13.00	0	4,555	0		1.00
2.00	PHARMACY	15.00	1,484,962	7,389,763	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	17,596	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	10,103	0		4.00
5.00	RECOVERY ROOM	51.00	0	37,064	0		5.00
6.00	ANESTHESIOLOGY	53.00	0	271,210	0		6.00
7.00	PAIN MANAGEMENT	53.01	0	1,920	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	18,016	0		8.00
9.00	ULTRASOUND	54.01	0	455	0		9.00
10.00	RADIOISOTOPE	56.00	0	211,714	0		10.00
11.00	CT SCAN	57.00	0	61,101	0		11.00
12.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	35,825	0		12.00
13.00	CARDIAC CATHETERIZATION	59.00	0	11,882	0		13.00
14.00	LABORATORY	60.00	0	1,600	0		14.00
15.00	RESPIRATORY THERAPY	65.00	0	1,652	0		15.00
16.00	ELECTROCARDIOLOGY	69.00	0	30,476	0		16.00
17.00	GI LAB	75.01	0	1,358	0		17.00
18.00	HYPERBARIC OXYGEN THERAPY	76.98	0	33,588	0		18.00
19.00	CLINIC	90.00	0	19,318,874	0		19.00
20.00	EMERGENCY	91.00	0	7,253	0		20.00
21.00	AMBULANCE SERVICES	95.00	0	6,589	0		21.00
	0		1,484,962	27,472,594			
	H - MARKETING & ADVERTISING						
1.00	NURSING ADMINISTRATION	13.00	0	431	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,117	0		2.00
3.00	HYPERBARIC OXYGEN THERAPY	76.98	0	466	0		3.00
4.00	CLINIC	90.00	0	550	0		4.00
5.00	HOME HEALTH AGENCY	101.00	0	1,177	0		5.00
6.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	21,365	0		6.00
7.00	OFFSITE FREESTANDING PT/OT	194.01	0	1,118	0		7.00
	0		0	30,224			
	I - TELEPHONE EXPENSE						
1.00	OPERATION OF PLANT	7.00	0	1,237	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	1,099	0		2.00
3.00	PHARMACY	15.00	0	2,601	0		3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	658	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	9,627	0		5.00
6.00	OPERATING ROOM	50.00	0	6,212	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	5,384	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	489	0		8.00
9.00	LABORATORY	60.00	0	1,920	0		9.00
10.00	ELECTROCARDIOLOGY	69.00	0	356	0		10.00
11.00	GI LAB	75.01	0	521	0		11.00
12.00	HYPERBARIC OXYGEN THERAPY	76.98	0	960	0		12.00
13.00	CLINIC	90.00	0	82,683	0		13.00
14.00	EMERGENCY	91.00	0	473	0		14.00
15.00	AMBULANCE SERVICES	95.00	0	4,835	0		15.00
16.00	HOME HEALTH AGENCY	101.00	0	6,501	0		16.00
17.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	12,429	0		17.00

RECLASSIFICATIONS

Provider CCN: 14-0043

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

Worksheet A-6

Date/Time Prepared:
9/29/2020 8:26 am

		Decreases								
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.					
	6.00	7.00	8.00	9.00	10.00					
	0		0	137,985						
J - PROPERTY INSURANCE & TAXES										
1.00	ADMINISTRATIVE & GENERAL	5.00	0	11,712	13				1.00	
2.00	OPERATION OF PLANT	7.00	0	328,686	0				2.00	
3.00	OPERATION OF PLANT	7.00	0	109,733	0				3.00	
4.00	AMBULANCE SERVICES	95.00	0	32,662	0				4.00	
5.00	HOME HEALTH AGENCY	101.00	0	20,717	0				5.00	
6.00	COMMUNITY SERVICE	194.00	0	1,755	0				6.00	
	0		0	505,265						
K - MALPRACTICE INSURANCE										
1.00	AMBULANCE SERVICES	95.00	0	17,200	0				1.00	
	0		0	17,200						
L - MEDICAL SUPPLIES										
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,923	0				1.00	
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	250,084	0				2.00	
3.00	PHARMACY	15.00	0	140,690	0				3.00	
4.00	ADULTS & PEDIATRICS	30.00	0	551,016	0				4.00	
5.00	INTENSIVE CARE UNIT	31.00	0	142,103	0				5.00	
6.00	OPERATING ROOM	50.00	0	5,856,742	0				6.00	
7.00	RECOVERY ROOM	51.00	0	172,493	0				7.00	
8.00	ANESTHESIOLOGY	53.00	0	234,413	0				8.00	
9.00	PAIN MANAGEMENT	53.01	0	41,862	0				9.00	
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	136,439	0				10.00	
11.00	ULTRASOUND	54.01	0	21,201	0				11.00	
12.00	RADIOISOTOPE	56.00	0	582,872	0				12.00	
13.00	CT SCAN	57.00	0	114,854	0				13.00	
14.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	10,735	0				14.00	
15.00	CARDIAC CATHETERIZATION	59.00	0	1,443,417	0				15.00	
16.00	LABORATORY	60.00	0	1,886,932	0				16.00	
17.00	RESPIRATORY THERAPY	65.00	0	179,470	0				17.00	
18.00	PHYSICAL THERAPY	66.00	0	1,458	0				18.00	
19.00	OCCUPATIONAL THERAPY	67.00	0	2,428	0				19.00	
20.00	SPEECH PATHOLOGY	68.00	0	1,179	0				20.00	
21.00	ELECTROCARDIOLOGY	69.00	0	46,042	0				21.00	
22.00	ELECTROENCEPHALOGRAPHY	70.00	0	37,971	0				22.00	
23.00	RENAL DIALYSIS	74.00	0	1,817	0				23.00	
24.00	GI LAB	75.01	0	848,619	0				24.00	
25.00	DIABETIC EDUCATION	76.00	0	8,019	0				25.00	
26.00	HYPERBARIC OXYGEN THERAPY	76.98	0	374,682	0				26.00	
27.00	CLINIC	90.00	0	874,307	0				27.00	
28.00	EMERGENCY	91.00	0	481,691	0				28.00	
29.00	AMBULANCE SERVICES	95.00	0	28,241	0				29.00	
30.00	HOME INFUSION	98.00	0	26,316	0				30.00	
31.00	HOME HEALTH AGENCY	101.00	0	24,390	0				31.00	
	0		0	14,524,406						
N - POST ICU										
1.00	INTENSIVE CARE UNIT	31.00	918,606	113,929	0				1.00	
	0		918,606	113,929						
O - MME DEPRECIATION										
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	7,392,404	9				1.00	
	0		0	7,392,404						
P - UTILITIES EXPENSE										
1.00	AMBULANCE SERVICES	95.00	0	7,506	0				1.00	
	0		0	7,506						
Q - NURSE FLOATS & SHIFT COORDINATORS										
1.00	NURSING ADMINISTRATION	13.00	766,539	0	0				1.00	
2.00		0.00	0	0	0				2.00	
3.00		0.00	0	0	0				3.00	
4.00		0.00	0	0	0				4.00	
	0		766,539	0						
R - RADIOLOGY MANAGEMENT										
1.00	ADMINISTRATIVE & GENERAL	5.00	593,912	28,795	0				1.00	
2.00		0.00	0	0	0				2.00	
3.00		0.00	0	0	0				3.00	
4.00		0.00	0	0	0				4.00	
5.00		0.00	0	0	0				5.00	
	0		593,912	28,795						
500.00	Grand Total: Decreases		6,112,412	52,907,448					500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0043

Period:
From 05/01/2019
To 04/30/2020Worksheet A-7
Part I
Date/Time Prepared:
9/29/2020 8:26 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,864,606	0	0	0	0	1.00
2.00	Land Improvements	4,171,678	334,065	0	334,065	763,401	2.00
3.00	Buildings and Fixtures	97,168,886	1,150,709	0	1,150,709	659,532	3.00
4.00	Building Improvements	12,424,709	0	0	0	1,029,281	4.00
5.00	Fixed Equipment	477,481	40,985	0	40,985	0	5.00
6.00	Movable Equipment	89,914,340	5,609,440	0	5,609,440	1,590,555	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	207,021,700	7,135,199	0	7,135,199	4,042,769	8.00
9.00	Reconciling Items	-1,774,252	-9,649,079	0	-9,649,079	-7,135,199	9.00
10.00	Total (line 8 minus line 9)	208,795,952	16,784,278	0	16,784,278	11,177,968	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,864,606	0				1.00
2.00	Land Improvements	3,742,342	0				2.00
3.00	Buildings and Fixtures	97,660,063	0				3.00
4.00	Building Improvements	11,395,428	0				4.00
5.00	Fixed Equipment	518,466	0				5.00
6.00	Movable Equipment	93,933,225	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	210,114,130	0				8.00
9.00	Reconciling Items	-4,288,132	0				9.00
10.00	Total (line 8 minus line 9)	214,402,262	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0043

Period:
From 05/01/2019
To 04/30/2020Worksheet A-7
Part II
Date/Time Prepared:
9/29/2020 8:26 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	11,275,813	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	11,275,813	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	11,275,813				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	11,275,813				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0043

Period:
From 05/01/2019
To 04/30/2020Worksheet A-7
Part III
Date/Time Prepared:
9/29/2020 8:26 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	115,662,439	0	115,662,439	0.550474	108,164	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	94,451,691	0	94,451,691	0.449526	88,329	2.00
3.00	Total (sum of lines 1-2)	210,114,130	0	210,114,130	1.000000	196,493	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	108,164	3,883,409	759,233	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	88,329	7,359,420	0	2.00
3.00	Total (sum of lines 1-2)	0	0	196,493	11,242,829	759,233	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	108,164	626,904	0	5,377,710	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	88,329	0	0	7,447,749	2.00
3.00	Total (sum of lines 1-2)	0	196,493	626,904	0	12,825,459	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0043

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

Worksheet A-8

Date/Time Prepared:
9/29/2020 8:26 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		B	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-263,303	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP 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)	B	-172,238	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-44,024,017			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	0	OPERATION OF PLANT	7.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service	B	-13,023	LAUNDRY & LINEN SERVICE	8.00	0	13.00
14.00	Cafeteria-employees and guests	B	-752,990	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-2,850,839	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-50,722	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	-306	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		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	DAYCARE RENT	B	-18,000	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0043

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

Worksheet A-8

Date/Time Prepared:
9/29/2020 8:26 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	
33.01	DIETARY CATERING REVENUE	B	-6,048	CAFETERIA	11.00	0	33.01
33.02	RENTAL INCOME	B	-820	OPERATION OF PLANT	7.00	0	33.02
33.03	MISC INCOME - PHARMACY	B	-3,000	PHARMACY	15.00	0	33.03
33.04	MISC INCOME - A&G	B	-106,002	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	MISC INCOME - RT	B	-2,908	RESPIRATORY THERAPY	65.00	0	33.05
33.06	MISC INCOME - AMBULANCE	B	-512	AMBULANCE SERVICES	95.00	0	33.06
33.07	MISC INCOME - A&P	B	-57	ADULTS & PEDIATRICS	30.00	0	33.07
33.08	IMMUNIZATION INCOME - HOME HEALTH	B	-199	HOME HEALTH AGENCY	101.00	0	33.08
33.09	CARDIAC REHAB PHASE III REVENUE	B	-10,167	ELECTROCARDIOLOGY	69.00	0	33.09
33.10	NON-ALLOWABLE COSTS	A	67	INTENSIVE CARE UNIT	31.00	0	33.10
33.11	BLOOD DRAW INCOME	B	-1,156	HOME INFUSION	98.00	0	33.11
33.12	HOUSEKEEPING REVENUE	B	-198	HOUSEKEEPING	9.00	0	33.12
33.13	PATIENT ACCOUNTING REVENUE	B	-100,374	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	DAYCARE REVENUE	B	-518,564	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	DAYCARE DISCOUNT EXPENSE ELIMINATION	A	-38,271	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.15
33.16	FORGIVENESS OF DEBT	A	13,341	ADMINISTRATIVE & GENERAL	5.00	0	33.16
35.00	NON-ALLOWABLE COSTS	A	-4,314	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	LOBBYING EXPENSE	A	-37,602	ADMINISTRATIVE & GENERAL	5.00	0	36.00
36.01	PHYSICIAN RECRUITMENT SALARIES	A	-88,176	ADMINISTRATIVE & GENERAL	5.00	0	36.01
36.02	PHYSICIAN RECRUITMENT OTHER EXPENSES	A	-516,057	ADMINISTRATIVE & GENERAL	5.00	0	36.02
36.03	PHYSICIAN RECRUITMENT BENEFITS	A	-42,086	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36.03
37.00	MARKETING SALARIES	A	-321,210	ADMINISTRATIVE & GENERAL	5.00	0	37.00
37.01	MARKETING OTHER EXPENSES	A	-596,126	ADMINISTRATIVE & GENERAL	5.00	0	37.01
37.02	MARKETING DEPRECIATION	A	-32,984	CAP REL COSTS-MVBLE EQUIP	2.00	9	37.02
37.03	MARKETING BENEFITS	A	-128,366	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37.03
38.00	CABLE TELEVISION	A	-41,769	ADMINISTRATIVE & GENERAL	5.00	0	38.00
38.01	CABLE TELEVISION	A	-4,188	CLINIC	90.00	0	38.01
39.00	CRNA SALARIES	A	-2,529,347	ANESTHESIOLOGY	53.00	0	39.00
39.01	CRNA LOCUM TENENS	A	-916,817	ANESTHESIOLOGY	53.00	0	39.01
39.02	CRNA MALPRACTICE INSURANCE	A	-59,314	ANESTHESIOLOGY	53.00	0	39.02
39.03	CRNA PHYSICIAN CME EXPENSE	A	-26,323	ANESTHESIOLOGY	53.00	0	39.03
39.04	CRNA FICA TAXES	A	-72,032	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.04
39.05	CRNA MEDICARE TAXES	A	-37,029	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.05
39.06	CRNA BENEFITS	A	-242,485	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.06
40.00	ALCOHOLIC BEVERAGE EXPENSE	A	-1,394	ADMINISTRATIVE & GENERAL	5.00	0	40.00
40.01	DEFINED BENEFIT PENSION FUNDING ADJU	A	642,361	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.01
41.00	PHYSICIAN BENEFITS	A	-4,185,871	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	41.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-58,161,435				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0043

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

Worksheet A-8-2

Date/Time Prepared:
9/29/2020 8:26 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	175,037	0	175,037	211,500	1,167	1.00
2.00	30.00	ADULTS & PEDIATRICS	2,712,269	2,712,269	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	55,147	55,147	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	53.01	PAIN MANAGEMENT	756,972	756,972	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	1,253,578	1,253,578	0	0	0	6.00
7.00	54.01	ULTRASOUND	569,357	569,357	0	0	0	7.00
8.00	56.00	RADIOISOTOPE	67,161	67,161	0	0	0	8.00
9.00	57.00	CT SCAN	1,867,017	1,867,017	0	0	0	9.00
10.00	58.00	MAGNETIC RESONANCE IMAGING (MRI)	641,680	641,680	0	0	0	10.00
11.00	60.00	LABORATORY	584,396	584,396	0	0	0	11.00
12.00	70.00	ELECTROENCEPHALOGRAPHY	2,591	2,591	0	0	0	12.00
13.00	76.00	DIABETIC EDUCATION	0	0	0	0	0	13.00
14.00	76.98	HYPERBARIC OXYGEN THERAPY	285,532	285,532	0	0	0	14.00
15.00	90.00	CLINIC	30,879,636	30,879,636	0	0	0	15.00
16.00	91.00	EMERGENCY	4,292,308	4,292,308	0	0	0	16.00
200.00			44,142,681	43,967,644	175,037		1,167	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	118,664	5,933	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	22,972	0	105,996	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	55,147	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	53.01	PAIN MANAGEMENT	0	0	0	0	15,538	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	54.01	ULTRASOUND	0	0	0	0	0	7.00
8.00	56.00	RADIOISOTOPE	0	0	0	0	0	8.00
9.00	57.00	CT SCAN	0	0	0	0	0	9.00
10.00	58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	10.00
11.00	60.00	LABORATORY	0	0	8,520	0	15,653	11.00
12.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	981	0	0	12.00
13.00	76.00	DIABETIC EDUCATION	0	0	0	0	0	13.00
14.00	76.98	HYPERBARIC OXYGEN THERAPY	0	0	1,316	0	-3,206	14.00
15.00	90.00	CLINIC	0	0	180,161	0	962,976	15.00
16.00	91.00	EMERGENCY	0	0	0	0	0	16.00
200.00			118,664	5,933	213,950	0	1,152,104	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	118,664	56,373	56,373		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,712,269		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	55,147		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0		4.00
5.00	53.01	PAIN MANAGEMENT	0	0	0	756,972		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,253,578		6.00
7.00	54.01	ULTRASOUND	0	0	0	569,357		7.00
8.00	56.00	RADIOISOTOPE	0	0	0	67,161		8.00
9.00	57.00	CT SCAN	0	0	0	1,867,017		9.00
10.00	58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	641,680		10.00
11.00	60.00	LABORATORY	0	0	0	584,396		11.00
12.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	2,591		12.00
13.00	76.00	DIABETIC EDUCATION	0	0	0	0		13.00
14.00	76.98	HYPERBARIC OXYGEN THERAPY	0	0	0	285,532		14.00
15.00	90.00	CLINIC	0	0	0	30,879,636		15.00
16.00	91.00	EMERGENCY	0	0	0	4,292,308		16.00
200.00			0	118,664	56,373	44,024,017		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0043

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part I
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Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	5,377,710	5,377,710			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	7,447,749	7,447,749			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	30,044,968	18,790	23,841	30,087,599	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	23,500,740	1,050,405	1,959,190	5,395,499	5.00
7.00	00700	OPERATION OF PLANT	4,215,494	167,295	74,261	632,887	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	397,856	64,308	34,654	128,759	8.00
9.00	00900	HOUSEKEEPING	2,541,184	6,687	24,633	570,800	9.00
10.00	01000	DIETARY	312,637	15,527	4,385	83,109	10.00
11.00	01100	CAFETERIA	661,559	68,057	19,497	369,586	11.00
13.00	01300	NURSING ADMINISTRATION	539,064	2,388	71,352	153,804	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	686,357	9,444	38,988	226,007	14.00
15.00	01500	PHARMACY	473,540	30,928	189,408	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,574,308	48,366	25,161	832,207	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,226,526	469,676	388,893	3,519,541	30.00
31.00	03100	INTENSIVE CARE UNIT	2,026,419	92,118	124,904	814,878	31.00
43.00	04300	NURSERY	564,115	77,682	49,398	240,525	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,191,883	220,023	780,930	617,113	50.00
51.00	05100	RECOVERY ROOM	1,254,142	74,789	79,338	395,322	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,170,906	94,705	102,310	499,246	52.00
53.00	05300	ANESTHESIOLOGY	42,237	5,786	37,543	0	53.00
53.01	05301	PAIN MANAGEMENT	252,117	27,107	9,982	108,324	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,109,699	167,448	729,120	643,233	54.00
54.01	05401	ULTRASOUND	699,208	5,164	56,967	287,430	54.01
56.00	05600	RADIOISOTOPE	328,646	40,895	123,742	100,487	56.00
57.00	05700	CT SCAN	994,905	17,267	136,887	296,215	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	508,486	32,217	255,722	178,573	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,339,494	71,031	459,602	312,899	59.00
60.00	06000	LABORATORY	4,820,017	101,923	173,987	1,092,396	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,077,397	47,114	116,350	412,418	65.00
66.00	06600	PHYSICAL THERAPY	449,650	24,494	1,268	201,682	66.00
67.00	06700	OCCUPATIONAL THERAPY	85,910	3,623	0	37,952	67.00
68.00	06800	SPEECH PATHOLOGY	152,325	1,081	0	64,744	68.00
69.00	06900	ELECTROCARDIOLOGY	1,033,922	36,759	95,586	423,564	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	212,057	11,850	15,677	90,793	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,524,406	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	26,106,717	0	0	677,065	73.00
74.00	07400	RENAL DIALYSIS	209,156	1,811	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01	07501	GI LAB	1,318,716	31,803	296,216	525,713	75.01
76.00	03950	DIABETIC EDUCATION	142,192	14,049	152	64,484	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	646,363	38,922	17,556	179,639	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	10,694,299	1,426,198	151,654	4,517,011	90.00
91.00	09100	EMERGENCY	3,628,548	188,499	652,090	1,602,548	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	1,828,209	28,540	69,018	767,349	95.00
98.00	09850	HOME INFUSION	218,337	1,901	2,038	29,622	98.00
101.00	10100	HOME HEALTH AGENCY	1,401,353	20,961	17,904	575,079	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	169,031,523	4,857,631	7,410,204	27,668,503	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	49,089	11,445	0	9,746	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,512,720	256,331	37,545	1,228,783	192.00
194.00	07950	COMMUNITY SERVICE	192,806	10,391	0	83,516	194.00
194.01	07951	OFFSITE FREESTANDING PT/OT	2,562,363	184,345	0	1,097,051	194.01
194.02	07952	OFFSITE BUILDINGS	0	57,567	0	0	194.02
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	175,348,501	5,377,710	7,447,749	30,087,599	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0043

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part I
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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	31,905,834					5.00
7.00	00700	OPERATION OF PLANT	1,132,150	6,222,087				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	139,146	96,621	861,344			8.00
9.00	00900	HOUSEKEEPING	699,162	10,047	63,806	3,916,319		9.00
10.00	01000	DIETARY	92,454	23,329	2,373	14,940	548,754	10.00
11.00	01100	CAFETERIA	248,831	102,254	10,553	65,484	0	11.00
13.00	01300	NURSING ADMINISTRATION	170,516	3,588	0	2,298	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	213,709	14,190	0	9,087	0	14.00
15.00	01500	PHARMACY	154,338	46,469	0	29,759	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	774,062	72,669	0	46,537	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,803,637	705,677	297,021	451,916	502,872	30.00
31.00	03100	INTENSIVE CARE UNIT	680,259	138,406	38,031	88,635	45,882	31.00
43.00	04300	NURSERY	207,242	116,715	15,783	74,744	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	847,443	330,579	92,462	211,703	0	50.00
51.00	05100	RECOVERY ROOM	401,171	112,368	0	71,961	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	415,312	142,292	32,764	91,124	0	52.00
53.00	05300	ANESTHESIOLOGY	19,032	8,693	0	5,567	0	53.00
53.01	05301	PAIN MANAGEMENT	88,422	40,728	0	26,082	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	811,755	251,587	46,090	161,116	0	54.00
54.01	05401	ULTRASOUND	233,277	7,758	0	4,968	0	54.01
56.00	05600	RADIOISOTOPE	132,072	61,444	0	39,349	0	56.00
57.00	05700	CT SCAN	321,471	25,943	0	16,614	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	216,868	48,405	0	30,999	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	485,568	106,722	0	68,345	0	59.00
60.00	06000	LABORATORY	1,376,462	153,137	0	98,069	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	367,737	70,787	0	45,332	0	65.00
66.00	06600	PHYSICAL THERAPY	150,605	36,802	0	23,568	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	28,356	5,443	0	3,486	0	67.00
68.00	06800	SPEECH PATHOLOGY	48,523	1,625	0	1,041	0	68.00
69.00	06900	ELECTROCARDIOLOGY	353,625	55,230	0	35,369	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	73,485	17,805	0	11,402	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,230,649	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	5,957,518	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	46,925	2,722	0	1,743	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	GI LAB	483,215	47,783	35,699	30,600	0	75.01
76.00	03950	DIABETIC EDUCATION	49,129	21,109	0	13,518	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	196,289	58,479	4,417	37,450	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,734,397	2,142,826	29,560	1,372,268	0	90.00
91.00	09100	EMERGENCY	1,350,519	283,216	156,650	181,372	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	599,027	42,881	20,668	27,461	0	95.00
98.00	09850	HOME INFUSION	56,029	2,857	0	1,830	0	98.00
101.00	10100	HOME HEALTH AGENCY	448,260	31,494	0	20,169	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,838,647	5,440,680	845,877	3,415,906	548,754	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,632	17,196	0	11,012	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,120,014	385,132	6,814	246,639	0	192.00
194.00	07950	COMMUNITY SERVICE	63,773	15,612	0	9,998	0	194.00
194.01	07951	OFFSITE FREESTANDING PT/OT	854,963	276,974	8,653	177,374	0	194.01
194.02	07952	OFFSITE BUILDINGS	12,805	86,493	0	55,390	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	31,905,834	6,222,087	861,344	3,916,319	548,754	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0043

Period:
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To 04/30/2020Worksheet B
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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	1,545,821					11.00
13.00	01300	NURSING ADMINISTRATION	6,441	949,451				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	17,545	0	1,215,327			14.00
15.00	01500	PHARMACY	0	0	410	924,852		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	60,652	0	1	0	4,433,963	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	223,704	216,514	2,803	0	232,962	30.00
31.00	03100	INTENSIVE CARE UNIT	43,586	44,330	2,497	0	44,701	31.00
43.00	04300	NURSERY	10,364	10,533	0	0	19,814	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	34,442	35,026	4,831	0	319,287	50.00
51.00	05100	RECOVERY ROOM	20,665	21,021	426	0	49,741	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	21,499	21,863	0	0	41,127	52.00
53.00	05300	ANESTHESIOLOGY	11,923	0	937	0	111,125	53.00
53.01	05301	PAIN MANAGEMENT	7,491	6,052	0	0	30,583	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	50,242	0	446	0	197,526	54.00
54.01	05401	ULTRASOUND	12,958	0	94	0	108,931	54.01
56.00	05600	RADIOISOTOPE	5,097	0	575	0	69,585	56.00
57.00	05700	CT SCAN	14,951	0	0	0	407,700	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	8,448	0	38	0	128,254	58.00
59.00	05900	CARDIAC CATHETERIZATION	13,746	13,984	696	0	125,714	59.00
60.00	06000	LABORATORY	82,476	0	1,757	0	631,699	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	21,824	0	923	0	47,846	65.00
66.00	06600	PHYSICAL THERAPY	10,116	0	0	0	11,580	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,838	0	0	0	3,650	67.00
68.00	06800	SPEECH PATHOLOGY	2,641	0	0	0	2,470	68.00
69.00	06900	ELECTROCARDIOLOGY	26,565	27,016	374	0	145,011	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	6,332	0	29	0	27,076	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,136,447	0	141,851	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,662	0	0	924,852	518,003	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	3,264	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	GI LAB	26,782	27,243	904	0	152,802	75.01
76.00	03950	DIABETIC EDUCATION	4,062	0	0	0	1,529	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	12,294	0	259	0	36,562	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	484,200	345,960	9,218	0	318,647	90.00
91.00	09100	EMERGENCY	94,029	95,632	1,644	0	329,832	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	48,034	0	67	0	33,132	95.00
98.00	09850	HOME INFUSION	1,683	1,717	0	0	7,558	98.00
101.00	10100	HOME HEALTH AGENCY	25,793	26,236	38	0	9,636	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,440,085	893,127	1,165,414	924,852	4,309,198	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,390	0	10	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	46,844	47,255	43,592	0	38,062	192.00
194.00	07950	COMMUNITY SERVICE	4,541	9,069	45	0	0	194.00
194.01	07951	OFFSITE FREESTANDING PT/OT	52,961	0	6,266	0	86,703	194.01
194.02	07952	OFFSITE BUILDINGS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,545,821	949,451	1,215,327	924,852	4,433,963	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0043

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	18,041,742	-606,901	17,434,841	30.00
31.00	03100	INTENSIVE CARE UNIT	4,184,646	-128,040	4,056,606	31.00
43.00	04300	NURSERY	1,386,915	0	1,386,915	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,685,722	0	5,685,722	50.00
51.00	05100	RECOVERY ROOM	2,480,944	159,412	2,640,356	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,633,148	0	2,633,148	52.00
53.00	05300	ANESTHESIOLOGY	242,843	0	242,843	53.00
53.01	05301	PAIN MANAGEMENT	596,888	0	596,888	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,168,262	0	5,168,262	54.00
54.01	05401	ULTRASOUND	1,416,755	0	1,416,755	54.01
56.00	05600	RADIOISOTOPE	901,892	0	901,892	56.00
57.00	05700	CT SCAN	2,231,953	0	2,231,953	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,408,010	0	1,408,010	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,997,801	0	2,997,801	59.00
60.00	06000	LABORATORY	8,531,923	0	8,531,923	60.00
64.00	06400	INTRAVENOUS THERAPY	0	575,529	575,529	64.00
65.00	06500	RESPIRATORY THERAPY	2,207,728	0	2,207,728	65.00
66.00	06600	PHYSICAL THERAPY	909,765	0	909,765	66.00
67.00	06700	OCCUPATIONAL THERAPY	170,258	0	170,258	67.00
68.00	06800	SPEECH PATHOLOGY	274,450	0	274,450	68.00
69.00	06900	ELECTROCARDIOLOGY	2,233,021	0	2,233,021	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	466,506	0	466,506	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,033,353	0	19,033,353	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,211,817	0	34,211,817	73.00
74.00	07400	RENAL DIALYSIS	265,621	0	265,621	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	75.00
75.01	07501	GI LAB	2,977,476	0	2,977,476	75.01
76.00	03950	DIABETIC EDUCATION	310,224	0	310,224	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,228,230	0	1,228,230	76.98
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	25,226,238	0	25,226,238	90.00
91.00	09100	EMERGENCY	8,564,579	0	8,564,579	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,464,386	0	3,464,386	95.00
98.00	09850	HOME INFUSION	323,572	0	323,572	98.00
101.00	10100	HOME HEALTH AGENCY	2,576,923	0	2,576,923	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	162,353,591	0	162,353,591	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	115,520	0	115,520	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,969,731	0	6,969,731	192.00
194.00	07950	COMMUNITY SERVICE	389,751	0	389,751	194.00
194.01	07951	OFFSITE FREESTANDING PT/OT	5,307,653	0	5,307,653	194.01
194.02	07952	OFFSITE BUILDINGS	212,255	0	212,255	194.02
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	175,348,501	0	175,348,501	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0043

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	18,790	23,841	42,631	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	67,007	1,050,405	1,959,190	3,076,602	5.00
7.00	00700	OPERATION OF PLANT	5,400	167,295	74,261	246,956	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	64,308	34,654	98,962	8.00
9.00	00900	HOUSEKEEPING	0	6,687	24,633	31,320	9.00
10.00	01000	DIETARY	0	15,527	4,385	19,912	10.00
11.00	01100	CAFETERIA	0	68,057	19,497	87,554	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,388	71,352	73,740	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	9,444	38,988	48,432	14.00
15.00	01500	PHARMACY	0	30,928	189,408	220,336	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	48,366	25,161	73,527	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	469,676	388,893	858,569	30.00
31.00	03100	INTENSIVE CARE UNIT	0	92,118	124,904	217,022	31.00
43.00	04300	NURSERY	0	77,682	49,398	127,080	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	84,966	220,023	780,930	1,085,919	50.00
51.00	05100	RECOVERY ROOM	0	74,789	79,338	154,127	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	94,705	102,310	197,015	52.00
53.00	05300	ANESTHESIOLOGY	0	5,786	37,543	43,329	53.00
53.01	05301	PAIN MANAGEMENT	0	27,107	9,982	37,089	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	167,448	729,120	896,568	54.00
54.01	05401	ULTRASOUND	0	5,164	56,967	62,131	54.01
56.00	05600	RADIOISOTOPE	0	40,895	123,742	164,637	56.00
57.00	05700	CT SCAN	0	17,267	136,887	154,154	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	32,217	255,722	287,939	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	71,031	459,602	530,633	59.00
60.00	06000	LABORATORY	0	101,923	173,987	275,910	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	47,114	116,350	163,464	65.00
66.00	06600	PHYSICAL THERAPY	0	24,494	1,268	25,762	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,623	0	3,623	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,081	0	1,081	68.00
69.00	06900	ELECTROCARDIOLOGY	0	36,759	95,586	132,345	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,128	11,850	15,677	28,655	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	1,811	0	1,811	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01	07501	GI LAB	0	31,803	296,216	328,019	75.01
76.00	03950	DIABETIC EDUCATION	0	14,049	152	14,201	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	38,922	17,556	56,478	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,400	1,426,198	151,654	1,580,252	90.00
91.00	09100	EMERGENCY	0	188,499	652,090	840,589	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	0	28,540	69,018	97,558	95.00
98.00	09850	HOME INFUSION	0	1,901	2,038	3,939	98.00
101.00	10100	HOME HEALTH AGENCY	0	20,961	17,904	38,865	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	160,901	4,857,631	7,410,204	12,428,736	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,445	0	11,445	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,500	256,331	37,545	295,376	192.00
194.00	07950	COMMUNITY SERVICE	0	10,391	0	10,391	194.00
194.01	07951	OFFSITE FREESTANDING PT/OT	0	184,345	0	184,345	194.01
194.02	07952	OFFSITE BUILDINGS	0	57,567	0	57,567	194.02
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)	162,401	5,377,710	7,447,749	12,987,860	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0043

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,084,248					5.00
7.00	00700	OPERATION OF PLANT	109,444	357,297				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	13,451	5,548	118,143			8.00
9.00	00900	HOUSEKEEPING	67,587	577	8,752	109,045		9.00
10.00	01000	DIETARY	8,937	1,340	326	416	31,049	10.00
11.00	01100	CAFETERIA	24,054	5,872	1,447	1,823	0	11.00
13.00	01300	NURSING ADMINISTRATION	16,484	206	0	64	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	20,659	815	0	253	0	14.00
15.00	01500	PHARMACY	14,920	2,668	0	829	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	74,828	4,173	0	1,296	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	271,025	40,523	40,740	12,583	28,453	30.00
31.00	03100	INTENSIVE CARE UNIT	65,760	7,948	5,216	2,468	2,596	31.00
43.00	04300	NURSERY	20,034	6,702	2,165	2,081	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	81,922	18,983	12,682	5,895	0	50.00
51.00	05100	RECOVERY ROOM	38,781	6,453	0	2,004	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	40,148	8,171	4,494	2,537	0	52.00
53.00	05300	ANESTHESIOLOGY	1,840	499	0	155	0	53.00
53.01	05301	PAIN MANAGEMENT	8,548	2,339	0	726	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	78,472	14,447	6,322	4,486	0	54.00
54.01	05401	ULTRASOUND	22,551	446	0	138	0	54.01
56.00	05600	RADIOISOTOPE	12,767	3,528	0	1,096	0	56.00
57.00	05700	CT SCAN	31,076	1,490	0	463	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	20,964	2,780	0	863	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	46,939	6,128	0	1,903	0	59.00
60.00	06000	LABORATORY	133,061	8,794	0	2,731	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	35,549	4,065	0	1,262	0	65.00
66.00	06600	PHYSICAL THERAPY	14,559	2,113	0	656	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,741	313	0	97	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,691	93	0	29	0	68.00
69.00	06900	ELECTROCARDIOLOGY	34,185	3,172	0	985	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,104	1,022	0	317	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	312,304	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	575,847	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	4,536	156	0	49	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	GI LAB	46,712	2,744	4,896	852	0	75.01
76.00	03950	DIABETIC EDUCATION	4,749	1,212	0	376	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	18,975	3,358	606	1,043	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	361,001	123,050	4,054	38,208	0	90.00
91.00	09100	EMERGENCY	130,553	16,263	21,486	5,050	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	57,907	2,462	2,835	765	0	95.00
98.00	09850	HOME INFUSION	5,416	164	0	51	0	98.00
101.00	10100	HOME HEALTH AGENCY	43,333	1,809	0	562	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,884,414	312,426	116,021	95,112	31,049	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,511	987	0	307	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	108,271	22,116	935	6,867	0	192.00
194.00	07950	COMMUNITY SERVICE	6,165	896	0	278	0	194.00
194.01	07951	OFFSITE FREESTANDING PT/OT	82,649	15,905	1,187	4,939	0	194.01
194.02	07952	OFFSITE BUILDINGS	1,238	4,967	0	1,542	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,084,248	357,297	118,143	109,045	31,049	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0043

Period:
From 05/01/2019
To 04/30/2020Worksheet B
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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	121,274					11.00
13.00	01300	NURSING ADMINISTRATION	505	91,217				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,376	0	71,855			14.00
15.00	01500	PHARMACY	0	0	24	238,777		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,758	0	0	0	159,761	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,550	20,801	166	0	8,412	30.00
31.00	03100	INTENSIVE CARE UNIT	3,419	4,259	148	0	1,614	31.00
43.00	04300	NURSERY	813	1,012	0	0	715	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,702	3,365	286	0	11,530	50.00
51.00	05100	RECOVERY ROOM	1,621	2,020	25	0	1,796	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,687	2,100	0	0	1,485	52.00
53.00	05300	ANESTHESIOLOGY	935	0	55	0	4,013	53.00
53.01	05301	PAIN MANAGEMENT	588	581	0	0	1,104	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,942	0	26	0	7,133	54.00
54.01	05401	ULTRASOUND	1,017	0	6	0	3,934	54.01
56.00	05600	RADIOISOTOPE	400	0	34	0	2,513	56.00
57.00	05700	CT SCAN	1,173	0	0	0	14,722	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	663	0	2	0	4,631	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,078	1,343	41	0	4,540	59.00
60.00	06000	LABORATORY	6,470	0	104	0	22,461	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,712	0	55	0	1,728	65.00
66.00	06600	PHYSICAL THERAPY	794	0	0	0	418	66.00
67.00	06700	OCCUPATIONAL THERAPY	144	0	0	0	132	67.00
68.00	06800	SPEECH PATHOLOGY	207	0	0	0	89	68.00
69.00	06900	ELECTROCARDIOLOGY	2,084	2,596	22	0	5,236	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	497	0	2	0	978	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	67,192	0	5,122	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,170	0	0	238,777	18,705	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	118	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	GI LAB	2,101	2,617	53	0	5,518	75.01
76.00	03950	DIABETIC EDUCATION	319	0	0	0	55	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	965	0	15	0	1,320	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	37,988	33,238	545	0	11,507	90.00
91.00	09100	EMERGENCY	7,377	9,188	97	0	11,910	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	3,768	0	4	0	1,196	95.00
98.00	09850	HOME INFUSION	132	165	0	0	273	98.00
101.00	10100	HOME HEALTH AGENCY	2,024	2,521	2	0	348	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	112,979	85,806	68,904	238,777	155,256	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	109	0	1	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,675	4,540	2,577	0	1,374	192.00
194.00	07950	COMMUNITY SERVICE	356	871	3	0	0	194.00
194.01	07951	OFFSITE FREESTANDING PT/OT	4,155	0	370	0	3,131	194.01
194.02	07952	OFFSITE BUILDINGS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	121,274	91,217	71,855	238,777	159,761	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0043

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part II
Date/Time Prepared:
9/29/2020 8:26 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	1,303,809	0	1,303,809	30.00
31.00	03100	INTENSIVE CARE UNIT	311,605	0	311,605	31.00
43.00	04300	NURSERY	160,943	0	160,943	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,224,158	0	1,224,158	50.00
51.00	05100	RECOVERY ROOM	207,387	0	207,387	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	258,344	0	258,344	52.00
53.00	05300	ANESTHESIOLOGY	50,826	0	50,826	53.00
53.01	05301	PAIN MANAGEMENT	51,128	0	51,128	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,012,307	0	1,012,307	54.00
54.01	05401	ULTRASOUND	90,630	0	90,630	54.01
56.00	05600	RADIOISOTOPE	185,117	0	185,117	56.00
57.00	05700	CT SCAN	203,498	0	203,498	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	318,095	0	318,095	58.00
59.00	05900	CARDIAC CATHETERIZATION	593,048	0	593,048	59.00
60.00	06000	LABORATORY	451,079	0	451,079	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	208,419	0	208,419	65.00
66.00	06600	PHYSICAL THERAPY	44,588	0	44,588	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,104	0	7,104	67.00
68.00	06800	SPEECH PATHOLOGY	6,282	0	6,282	68.00
69.00	06900	ELECTROCARDIOLOGY	181,225	0	181,225	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	38,704	0	38,704	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	384,618	0	384,618	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	836,458	0	836,458	73.00
74.00	07400	RENAL DIALYSIS	6,670	0	6,670	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	75.00
75.01	07501	GI LAB	394,257	0	394,257	75.01
76.00	03950	DIABETIC EDUCATION	21,003	0	21,003	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	83,015	0	83,015	76.98
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,196,243	0	2,196,243	90.00
91.00	09100	EMERGENCY	1,044,784	0	1,044,784	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	167,582	0	167,582	95.00
98.00	09850	HOME INFUSION	10,182	0	10,182	98.00
101.00	10100	HOME HEALTH AGENCY	90,279	0	90,279	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,143,387	0	12,143,387	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,374	0	14,374	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	447,472	0	447,472	192.00
194.00	07950	COMMUNITY SERVICE	19,078	0	19,078	194.00
194.01	07951	OFFSITE FREESTANDING PT/OT	298,235	0	298,235	194.01
194.02	07952	OFFSITE BUILDINGS	65,314	0	65,314	194.02
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	12,987,860	0	12,987,860	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0043

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

Worksheet B-1

Date/Time Prepared:
9/29/2020 8:26 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	596,742				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		7,359,420			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,085	23,558	65,989,173		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	116,559	1,935,953	11,833,649	-31,905,834	5.00
7.00	00700	OPERATION OF PLANT	18,564	73,380	1,388,068	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,136	34,243	282,399	0	8.00
9.00	00900	HOUSEKEEPING	742	24,341	1,251,897	0	9.00
10.00	01000	DIETARY	1,723	4,333	182,278	0	10.00
11.00	01100	CAFETERIA	7,552	19,266	810,589	0	11.00
13.00	01300	NURSING ADMINISTRATION	265	70,506	337,328	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,048	38,526	495,687	0	14.00
15.00	01500	PHARMACY	3,432	187,162	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,367	24,863	1,825,223	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	52,118	384,281	7,719,172	0	30.00
31.00	03100	INTENSIVE CARE UNIT	10,222	123,423	1,787,216	0	31.00
43.00	04300	NURSERY	8,620	48,812	527,528	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	24,415	771,668	1,353,473	0	50.00
51.00	05100	RECOVERY ROOM	8,299	78,397	867,034	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,509	101,097	1,094,963	0	52.00
53.00	05300	ANESTHESIOLOGY	642	37,098	0	0	53.00
53.01	05301	PAIN MANAGEMENT	3,008	9,864	237,579	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,581	720,473	1,410,759	0	54.00
54.01	05401	ULTRASOUND	573	56,291	630,401	0	54.01
56.00	05600	RADIOISOTOPE	4,538	122,274	220,391	0	56.00
57.00	05700	CT SCAN	1,916	135,264	649,668	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,575	252,689	391,653	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,882	454,151	686,261	0	59.00
60.00	06000	LABORATORY	11,310	171,924	2,395,878	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	5,228	114,970	904,529	0	65.00
66.00	06600	PHYSICAL THERAPY	2,718	1,253	442,335	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	402	0	83,237	0	67.00
68.00	06800	SPEECH PATHOLOGY	120	0	141,999	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,079	94,452	928,975	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,315	15,491	199,131	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,484,962	0	73.00
74.00	07400	RENAL DIALYSIS	201	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01	07501	GI LAB	3,529	292,703	1,153,011	0	75.01
76.00	03950	DIABETIC EDUCATION	1,559	150	141,429	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	4,319	17,348	393,991	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	158,259	149,855	9,906,855	0	90.00
91.00	09100	EMERGENCY	20,917	644,356	3,514,761	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	3,167	68,199	1,682,975	0	95.00
98.00	09850	HOME INFUSION	211	2,014	64,967	0	98.00
101.00	10100	HOME HEALTH AGENCY	2,326	17,692	1,261,283	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	539,031	7,322,320	60,683,534	-31,905,834	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,270	0	21,376	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	28,444	37,100	2,695,007	0	192.00
194.00	07950	COMMUNITY SERVICE	1,153	0	183,169	0	194.00
194.01	07951	OFFSITE FREESTANDING PT/OT	20,456	0	2,406,087	0	194.01
194.02	07952	OFFSITE BUILDINGS	6,388	0	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,377,710	7,447,749	30,087,599		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.011784	1.012002	0.455948		203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0043

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

Worksheet B-1

Date/Time Prepared:
9/29/2020 8:26 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
204.00		Cost to be allocated (per Wkst. B, Part II)			42,631		3,084,248	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000646		0.021502	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: 14-0043

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

Worksheet B-1

Date/Time Prepared:
9/29/2020 8:26 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		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	459,534				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,136	824,555			8.00
9.00	00900	HOUSEKEEPING	742	61,081	451,656		9.00
10.00	01000	DIETARY	1,723	2,272	1,723	44,767	10.00
11.00	01100	CAFETERIA	7,552	10,102	7,552	0	11.00
13.00	01300	NURSING ADMINISTRATION	265	0	265	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,048	0	1,048	0	14.00
15.00	01500	PHARMACY	3,432	0	3,432	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,367	0	5,367	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	52,118	284,336	52,118	41,024	30.00
31.00	03100	INTENSIVE CARE UNIT	10,222	36,407	10,222	3,743	31.00
43.00	04300	NURSERY	8,620	15,109	8,620	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	24,415	88,513	24,415	0	50.00
51.00	05100	RECOVERY ROOM	8,299	0	8,299	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,509	31,365	10,509	0	52.00
53.00	05300	ANESTHESIOLOGY	642	0	642	0	53.00
53.01	05301	PAIN MANAGEMENT	3,008	0	3,008	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,581	44,121	18,581	0	54.00
54.01	05401	ULTRASOUND	573	0	573	0	54.01
56.00	05600	RADIOISOTOPE	4,538	0	4,538	0	56.00
57.00	05700	CT SCAN	1,916	0	1,916	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,575	0	3,575	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,882	0	7,882	0	59.00
60.00	06000	LABORATORY	11,310	0	11,310	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	5,228	0	5,228	0	65.00
66.00	06600	PHYSICAL THERAPY	2,718	0	2,718	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	402	0	402	0	67.00
68.00	06800	SPEECH PATHOLOGY	120	0	120	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,079	0	4,079	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,315	0	1,315	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	201	0	201	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01	07501	GI LAB	3,529	34,174	3,529	0	75.01
76.00	03950	DIABETIC EDUCATION	1,559	0	1,559	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	4,319	4,228	4,319	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	158,259	28,297	158,259	0	90.00
91.00	09100	EMERGENCY	20,917	149,959	20,917	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	3,167	19,785	3,167	0	95.00
98.00	09850	HOME INFUSION	211	0	211	0	98.00
101.00	10100	HOME HEALTH AGENCY	2,326	0	2,326	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	401,823	809,749	393,945	44,767	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,270	0	1,270	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	28,444	6,523	28,444	0	192.00
194.00	07950	COMMUNITY SERVICE	1,153	0	1,153	0	194.00
194.01	07951	OFFSITE FREESTANDING PT/OT	20,456	8,283	20,456	0	194.01
194.02	07952	OFFSITE BUILDINGS	6,388	0	6,388	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,222,087	861,344	3,916,319	548,754	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.539993	1.044617	8.671022	12.258003	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	357,297	118,143	109,045	31,049	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.777520	0.143281	0.241434	0.693569	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0043

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

Worksheet B-1

Date/Time Prepared:
9/29/2020 8:26 am

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
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: 14-0043

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

Worksheet B-1

Date/Time Prepared:
9/29/2020 8:26 am

Cost Center Description			NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			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	1,257,255				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	15,532,529			14.00
15.00	01500	PHARMACY	0	5,239	27,203,449		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	19	0	734,436,189	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	286,706	35,830	0	38,588,991	30.00
31.00	03100	INTENSIVE CARE UNIT	58,702	31,919	0	7,404,587	31.00
43.00	04300	NURSERY	13,948	0	0	3,282,102	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	46,381	61,739	0	52,888,354	50.00
51.00	05100	RECOVERY ROOM	27,836	5,448	0	8,239,358	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	28,951	0	0	6,812,508	52.00
53.00	05300	ANESTHESIOLOGY	0	11,974	0	18,407,373	53.00
53.01	05301	PAIN MANAGEMENT	8,014	0	0	5,065,952	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,694	0	32,719,279	54.00
54.01	05401	ULTRASOUND	0	1,200	0	18,043,866	54.01
56.00	05600	RADIOISOTOPE	0	7,355	0	11,526,378	56.00
57.00	05700	CT SCAN	0	0	0	67,533,499	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	484	0	21,244,608	58.00
59.00	05900	CARDIAC CATHETERIZATION	18,517	8,889	0	20,823,965	59.00
60.00	06000	LABORATORY	0	22,457	0	104,609,306	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	11,796	0	7,925,484	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,918,140	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	604,681	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	409,068	68.00
69.00	06900	ELECTROCARDIOLOGY	35,774	4,774	0	24,020,297	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	368	0	4,485,030	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,524,406	0	23,496,926	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	27,203,449	85,804,707	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	540,693	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01	07501	GI LAB	36,075	11,553	0	25,310,961	75.01
76.00	03950	DIABETIC EDUCATION	0	0	0	253,350	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	3,309	0	6,056,344	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	458,119	117,807	0	52,782,337	90.00
91.00	09100	EMERGENCY	126,635	21,009	0	54,635,085	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	861	0	5,488,085	95.00
98.00	09850	HOME INFUSION	2,273	0	0	1,251,899	98.00
101.00	10100	HOME HEALTH AGENCY	34,741	485	0	1,596,179	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,182,672	14,894,615	27,203,449	713,769,392	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	126	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	62,574	557,131	0	6,304,839	192.00
194.00	07950	COMMUNITY SERVICE	12,009	571	0	0	194.00
194.01	07951	OFFSITE FREESTANDING PT/OT	0	80,086	0	14,361,958	194.01
194.02	07952	OFFSITE BUILDINGS	0	0	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	949,451	1,215,327	924,852	4,433,963	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.755178	0.078244	0.033998	0.006037	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	91,217	71,855	238,777	159,761	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0043

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

Worksheet B-1

Date/Time Prepared:
9/29/2020 8:26 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
		13.00	14.00	15.00	16.00		
205.00	Unit cost multiplier (Wkst. B, Part II)	0.072553	0.004626	0.008777	0.000218		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

Provider CCN: 14-0043

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

Worksheet B-2

Date/Time Prepared:
9/29/2020 8:26 am

		Description	Worksheet		Amount	
			CODE	Line No.		
			1.00	2.00	3.00	4.00
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS		1	74.00	0
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM		1	94.00	0
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1	74.00	0
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM		1	94.00	0
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS		1	74.00	0
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM		1	94.00	0
7.00		ADULTS AND PEDIATRICS		1	30.00	-606,901
8.00		INTENSIVE CARE UNIT		1	31.00	-128,040
9.00		RECOVERY ROOM		1	51.00	159,412
10.00		IV THERAPY		1	64.00	575,529

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0043

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part I
Date/Time Prepared:
9/29/2020 8:26 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	17,434,841		17,434,841	30.00
31.00	03100	INTENSIVE CARE UNIT	4,056,606		4,056,606	31.00
43.00	04300	NURSERY	1,386,915		1,386,915	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,685,722		5,685,722	50.00
51.00	05100	RECOVERY ROOM	2,640,356		2,640,356	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,633,148		2,633,148	52.00
53.00	05300	ANESTHESIOLOGY	242,843		242,843	53.00
53.01	05301	PAIN MANAGEMENT	596,888		596,888	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,168,262		5,168,262	54.00
54.01	05401	ULTRASOUND	1,416,755		1,416,755	54.01
56.00	05600	RADIOISOTOPE	901,892		901,892	56.00
57.00	05700	CT SCAN	2,231,953		2,231,953	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,408,010		1,408,010	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,997,801		2,997,801	59.00
60.00	06000	LABORATORY	8,531,923		8,531,923	60.00
64.00	06400	INTRAVENOUS THERAPY	575,529		575,529	64.00
65.00	06500	RESPIRATORY THERAPY	2,207,728	0	2,207,728	65.00
66.00	06600	PHYSICAL THERAPY	909,765	0	909,765	66.00
67.00	06700	OCCUPATIONAL THERAPY	170,258	0	170,258	67.00
68.00	06800	SPEECH PATHOLOGY	274,450	0	274,450	68.00
69.00	06900	ELECTROCARDIOLOGY	2,233,021		2,233,021	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	466,506		466,506	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,033,353		19,033,353	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,211,817		34,211,817	73.00
74.00	07400	RENAL DIALYSIS	265,621		265,621	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	75.00
75.01	07501	GI LAB	2,977,476		2,977,476	75.01
76.00	03950	DIABETIC EDUCATION	310,224		310,224	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,228,230		1,228,230	76.98
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	25,226,238		25,226,238	90.00
91.00	09100	EMERGENCY	8,564,579		8,564,579	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,576,390		3,576,390	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,464,386		3,464,386	95.00
98.00	09850	HOME INFUSION	323,572		323,572	98.00
101.00	10100	HOME HEALTH AGENCY	2,576,923		2,576,923	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)	165,929,981	0	165,929,981	200.00
201.00		Less Observation Beds	3,576,390		3,576,390	201.00
202.00		Total (see instructions)	162,353,591	0	162,353,591	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0043

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part I
Date/Time Prepared:
9/29/2020 8:26 am

			Title XVIII			Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	25,442,713		25,442,713			30.00
31.00	03100	INTENSIVE CARE UNIT	6,707,126		6,707,126			31.00
43.00	04300	NURSERY	3,282,102		3,282,102			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	17,038,932	35,849,422	52,888,354	0.107504	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,711,527	8,027,622	9,739,149	0.271107	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,527,052	2,285,456	6,812,508	0.386517	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	7,194,495	11,212,878	18,407,373	0.013193	0.000000	53.00
53.01	05301	PAIN MANAGEMENT	65,002	5,000,950	5,065,952	0.117823	0.000000	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,701,668	29,017,611	32,719,279	0.157958	0.000000	54.00
54.01	05401	ULTRASOUND	1,431,446	16,612,420	18,043,866	0.078517	0.000000	54.01
56.00	05600	RADIOISOTOPE	723,457	10,802,921	11,526,378	0.078246	0.000000	56.00
57.00	05700	CT SCAN	11,291,079	56,242,420	67,533,499	0.033050	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,672,261	19,572,347	21,244,608	0.066276	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	8,552,374	12,271,591	20,823,965	0.143959	0.000000	59.00
60.00	06000	LABORATORY	20,726,976	83,882,330	104,609,306	0.081560	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	450,945	5,329,650	5,780,595	0.099562	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	5,285,601	2,639,883	7,925,484	0.278561	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,669,561	248,579	1,918,140	0.474295	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	555,444	49,237	604,681	0.281567	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	181,717	227,351	409,068	0.670915	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	5,291,932	18,728,365	24,020,297	0.092964	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	130,859	4,354,171	4,485,030	0.104014	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,045,537	11,451,389	23,496,926	0.810036	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,582,157	70,222,550	85,804,707	0.398717	0.000000	73.00
74.00	07400	RENAL DIALYSIS	497,140	43,553	540,693	0.491260	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
75.01	07501	GI LAB	2,050,463	23,260,498	25,310,961	0.117636	0.000000	75.01
76.00	03950	DIABETIC EDUCATION	0	253,350	253,350	1.224488	0.000000	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	37,163	6,019,181	6,056,344	0.202801	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	73,082	52,709,255	52,782,337	0.477930	0.000000	90.00
91.00	09100	EMERGENCY	11,506,476	43,128,609	54,635,085	0.156760	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	969,310	5,594,043	6,563,353	0.544903	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	5,488,085	5,488,085	0.631256	0.000000	95.00
98.00	09850	HOME INFUSION	0	1,251,899	1,251,899	0.258465	0.000000	98.00
101.00	10100	HOME HEALTH AGENCY	0	1,596,179	1,596,179			101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	170,395,597	543,373,795	713,769,392			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	170,395,597	543,373,795	713,769,392			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0043

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part I
Date/Time Prepared:
9/29/2020 8:26 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.107504		50.00
51.00	05100	RECOVERY ROOM	0.271107		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.386517		52.00
53.00	05300	ANESTHESIOLOGY	0.013193		53.00
53.01	05301	PAIN MANAGEMENT	0.117823		53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.157958		54.00
54.01	05401	ULTRASOUND	0.078517		54.01
56.00	05600	RADIOISOTOPE	0.078246		56.00
57.00	05700	CT SCAN	0.033050		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.066276		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.143959		59.00
60.00	06000	LABORATORY	0.081560		60.00
64.00	06400	INTRAVENOUS THERAPY	0.099562		64.00
65.00	06500	RESPIRATORY THERAPY	0.278561		65.00
66.00	06600	PHYSICAL THERAPY	0.474295		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.281567		67.00
68.00	06800	SPEECH PATHOLOGY	0.670915		68.00
69.00	06900	ELECTROCARDIOLOGY	0.092964		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.104014		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.810036		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.398717		73.00
74.00	07400	RENAL DIALYSIS	0.491260		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
75.01	07501	GI LAB	0.117636		75.01
76.00	03950	DIABETIC EDUCATION	1.224488		76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.202801		76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.477930		90.00
91.00	09100	EMERGENCY	0.156760		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.544903		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.631256		95.00
98.00	09850	HOME INFUSION	0.258465		98.00
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0043

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part I
Date/Time Prepared:
9/29/2020 8:26 am

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,303,809	0	1,303,809	14,430	90.35	30.00
31.00	INTENSIVE CARE UNIT	311,605		311,605	1,330	234.29	31.00
43.00	NURSERY	160,943		160,943	918	175.32	43.00
200.00	Total (lines 30 through 199)	1,776,357		1,776,357	16,678		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	6,286	567,940				30.00
31.00	INTENSIVE CARE UNIT	809	189,541				31.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	7,095	757,481				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0043

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part II
Date/Time Prepared:
9/29/2020 8:26 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	1,224,158	52,888,354	0.023146	7,697,615	178,169	50.00
51.00	05100	RECOVERY ROOM	207,387	9,739,149	0.021294	905,853	19,289	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	258,344	6,812,508	0.037922	17,632	669	52.00
53.00	05300	ANESTHESIOLOGY	50,826	18,407,373	0.002761	3,467,073	9,573	53.00
53.01	05301	PAIN MANAGEMENT	51,128	5,065,952	0.010092	49,534	500	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,012,307	32,719,279	0.030939	2,223,201	68,784	54.00
54.01	05401	ULTRASOUND	90,630	18,043,866	0.005023	763,142	3,833	54.01
56.00	05600	RADIOISOTOPE	185,117	11,526,378	0.016060	431,962	6,937	56.00
57.00	05700	CT SCAN	203,498	67,533,499	0.003013	6,404,828	19,298	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	318,095	21,244,608	0.014973	838,647	12,557	58.00
59.00	05900	CARDIAC CATHETERIZATION	593,048	20,823,965	0.028479	4,383,583	124,840	59.00
60.00	06000	LABORATORY	451,079	104,609,306	0.004312	11,027,500	47,551	60.00
64.00	06400	INTRAVENOUS THERAPY	0	5,780,595	0.000000	264,334	0	64.00
65.00	06500	RESPIRATORY THERAPY	208,419	7,925,484	0.026297	3,374,239	88,732	65.00
66.00	06600	PHYSICAL THERAPY	44,588	1,918,140	0.023245	1,089,507	25,326	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,104	604,681	0.011748	343,367	4,034	67.00
68.00	06800	SPEECH PATHOLOGY	6,282	409,068	0.015357	125,238	1,923	68.00
69.00	06900	ELECTROCARDIOLOGY	181,225	24,020,297	0.007545	3,175,696	23,961	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	38,704	4,485,030	0.008630	85,681	739	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	384,618	23,496,926	0.016369	6,649,237	108,841	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	836,458	85,804,707	0.009748	8,391,029	81,796	73.00
74.00	07400	RENAL DIALYSIS	6,670	540,693	0.012336	355,079	4,380	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	07501	GI LAB	394,257	25,310,961	0.015577	1,063,108	16,560	75.01
76.00	03950	DIABETIC EDUCATION	21,003	253,350	0.082901	0	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	83,015	6,056,344	0.013707	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,196,243	52,782,337	0.041609	54,031	2,248	90.00
91.00	09100	EMERGENCY	1,044,784	54,635,085	0.019123	6,566,192	125,565	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	267,450	6,563,353	0.040749	550,922	22,450	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	HOME INFUSION	10,182	1,251,899	0.008133	0	0	98.00
200.00		Total (lines 50 through 199)	10,376,619	671,253,187		70,298,230	998,555	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0043		Period: From 05/01/2019 To 04/30/2020		Worksheet D Part III Date/Time Prepared: 9/29/2020 8:26 am	
					Title XVIII		Hospital		PPS	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00
43.00	04300	NURSERY		0	0	0	0	0	0	43.00
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	14,430	0.00		6,286	30.00
31.00	03100	INTENSIVE CARE UNIT			0	1,330	0.00		809	31.00
43.00	04300	NURSERY			0	918	0.00		0	43.00
200.00		Total (lines 30 through 199)			0	16,678			7,095	200.00
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
					9.00					
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0						30.00
31.00	03100	INTENSIVE CARE UNIT		0						31.00
43.00	04300	NURSERY		0						43.00
200.00		Total (lines 30 through 199)		0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0043		Period: From 05/01/2019 To 04/30/2020		Worksheet D Part IV Date/Time Prepared: 9/29/2020 8:26 am	
			Title XVIII		Hospital		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
53.01	05301	PAIN MANAGEMENT	0	0	0	0	0	53.01
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	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	GI LAB	0	0	0	0	0	75.01
76.00	03950	DIABETIC EDUCATION	0	0	0	0	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	HOME INFUSION	0	0	0	0	0	98.00
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: 14-0043		Period: From 05/01/2019 To 04/30/2020		Worksheet D Part IV Date/Time Prepared: 9/29/2020 8:26 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	52,888,354	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	9,739,149	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	6,812,508	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	18,407,373	0.000000	53.00
53.01	05301	PAIN MANAGEMENT	0	0	0	5,065,952	0.000000	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	32,719,279	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	18,043,866	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	11,526,378	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	67,533,499	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	21,244,608	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	20,823,965	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	104,609,306	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	5,780,595	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,925,484	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,918,140	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	604,681	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	409,068	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	24,020,297	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	4,485,030	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	23,496,926	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	85,804,707	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	540,693	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
75.01	07501	GI LAB	0	0	0	25,310,961	0.000000	75.01
76.00	03950	DIABETIC EDUCATION	0	0	0	253,350	0.000000	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	6,056,344	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	52,782,337	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	54,635,085	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	6,563,353	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0.000000	95.00
98.00	09850	HOME INFUSION	0	0	0	1,251,899	0.000000	98.00
200.00		Total (lines 50 through 199)	0	0	0	671,253,187		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0043

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part IV
Date/Time Prepared:
9/29/2020 8:26 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	7,697,615	0	10,741,198	0	50.00	
51.00	05100	RECOVERY ROOM	0.000000	905,853	0	2,518,610	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	17,632	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.000000	3,467,073	0	3,097,528	0	53.00	
53.01	05301	PAIN MANAGEMENT	0.000000	49,534	0	3,723,518	0	53.01	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,223,201	0	8,455,281	0	54.00	
54.01	05401	ULTRASOUND	0.000000	763,142	0	4,019,794	0	54.01	
56.00	05600	RADIOISOTOPE	0.000000	431,962	0	4,874,711	0	56.00	
57.00	05700	CT SCAN	0.000000	6,404,828	0	22,041,267	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	838,647	0	6,271,792	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.000000	4,383,583	0	6,038,145	0	59.00	
60.00	06000	LABORATORY	0.000000	11,027,500	0	15,823,689	0	60.00	
64.00	06400	INTRAVENOUS THERAPY	0.000000	264,334	0	2,315,503	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0.000000	3,374,239	0	1,111,846	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	1,089,507	0	59,587	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	343,367	0	11,275	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	125,238	0	7,401	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.000000	3,175,696	0	5,979,729	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	85,681	0	1,360,716	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	6,649,237	0	4,055,681	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	8,391,029	0	32,373,682	0	73.00	
74.00	07400	RENAL DIALYSIS	0.000000	355,079	0	29,392	0	74.00	
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00	
75.01	07501	GI LAB	0.000000	1,063,108	0	7,335,321	0	75.01	
76.00	03950	DIABETIC EDUCATION	0.000000	0	0	11,645	0	76.00	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	671,983	0	76.98	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	54,031	0	19,940,089	0	90.00	
91.00	09100	EMERGENCY	0.000000	6,566,192	0	11,409,718	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	550,922	0	2,357,271	0	92.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00	
98.00	09850	HOME INFUSION	0.000000	0	0	0	0	98.00	
200.00		Total (lines 50 through 199)		70,298,230	0	176,636,372	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0043

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part V
Date/Time Prepared:
9/29/2020 8:26 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	0.107504	10,741,198	0	0	1,154,722	50.00
51.00	05100	RECOVERY ROOM	0.271107	2,518,610	0	0	682,813	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.386517	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.013193	3,097,528	0	0	40,866	53.00
53.01	05301	PAIN MANAGEMENT	0.117823	3,723,518	0	0	438,716	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.157958	8,455,281	0	0	1,335,579	54.00
54.01	05401	ULTRASOUND	0.078517	4,019,794	0	0	315,622	54.01
56.00	05600	RADIOISOTOPE	0.078246	4,874,711	0	0	381,427	56.00
57.00	05700	CT SCAN	0.033050	22,041,267	0	0	728,464	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.066276	6,271,792	0	0	415,669	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.143959	6,038,145	0	0	869,245	59.00
60.00	06000	LABORATORY	0.081560	15,823,689	0	0	1,290,580	60.00
64.00	06400	INTRAVENOUS THERAPY	0.099562	2,315,503	0	0	230,536	64.00
65.00	06500	RESPIRATORY THERAPY	0.278561	1,111,846	0	0	309,717	65.00
66.00	06600	PHYSICAL THERAPY	0.474295	59,587	0	0	28,262	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.281567	11,275	0	0	3,175	67.00
68.00	06800	SPEECH PATHOLOGY	0.670915	7,401	0	0	4,965	68.00
69.00	06900	ELECTROCARDIOLOGY	0.092964	5,979,729	0	0	555,900	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.104014	1,360,716	0	0	141,534	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.810036	4,055,681	0	0	3,285,248	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	0.398717	32,373,682	1,449	333,007	12,907,937	73.00
74.00	07400	RENAL DIALYSIS	0.491260	29,392	0	0	14,439	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	07501	GI LAB	0.117636	7,335,321	0	0	862,898	75.01
76.00	03950	DIABETIC EDUCATION	1.224488	11,645	0	0	14,259	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.202801	671,983	0	0	136,279	76.98
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.477930	19,940,089	0	0	9,529,967	90.00
91.00	09100	EMERGENCY	0.156760	11,409,718	0	0	1,788,587	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.544903	2,357,271	0	0	1,284,484	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.631256		0			95.00
98.00	09850	HOME INFUSION	0.258465	0	0	0	0	98.00
200.00		Subtotal (see instructions)		176,636,372	1,449	333,007	38,751,890	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		176,636,372	1,449	333,007	38,751,890	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0043

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part V
Date/Time Prepared:
9/29/2020 8:26 am

			Title XVIII		Hospital	PPS
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
53.01	05301	PAIN MANAGEMENT	0	0		53.01
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	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	578	132,776		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	07501	GI LAB	0	0		75.01
76.00	03950	DIABETIC EDUCATION	0	0		76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
98.00	09850	HOME INFUSION	0	0		98.00
200.00		Subtotal (see instructions)	578	132,776		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	578	132,776		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0043

Period:

Worksheet D

Component CCN: 14-U043

From 05/01/2019

Part V

To 04/30/2020

Date/Time Prepared:

9/29/2020 8:26 am

			Title XVIII	Swing Beds - SNF		PPS		
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.107504	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.271107	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.386517	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.013193	0	0	0	0	53.00
53.01	05301	PAIN MANAGEMENT	0.117823	0	0	0	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.157958	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.078517	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.078246	0	0	0	0	56.00
57.00	05700	CT SCAN	0.033050	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.066276	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.143959	0	0	0	0	59.00
60.00	06000	LABORATORY	0.081560	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.099562	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.278561	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.474295	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.281567	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.670915	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.092964	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.104014	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.810036	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	0.398717	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.491260	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	07501	GI LAB	0.117636	0	0	0	0	75.01
76.00	03950	DIABETIC EDUCATION	1.224488	0	0	0	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.202801	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.477930	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.156760	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.544903	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.631256		0			95.00
98.00	09850	HOME INFUSION	0.258465		0			98.00
200.00		Subtotal (see instructions)		0		0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0		201.00
202.00		Net Charges (line 200 - line 201)		0		0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0043

Period:

Worksheet D

Component CCN: 14-U043

From 05/01/2019
To 04/30/2020Part V
Date/Time Prepared:
9/29/2020 8:26 am

Title XVIII

Swing Beds - SNF

PPS

Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
6.00			7.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		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
53.01	05301	PAIN MANAGEMENT	0	0		53.01
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	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	07501	GI LAB	0	0		75.01
76.00	03950	DIABETIC EDUCATION	0	0		76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0			95.00
98.00	09850	HOME INFUSION	0	0		98.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0043	Period: From 05/01/2019 To 04/30/2020	Worksheet D-1 Date/Time Prepared: 9/29/2020 8:26 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)		14,430	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		14,430	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)		11,470	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)		6,286	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)		17,434,841	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)		17,434,841	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)		17,434,841	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)		1,208.24	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		7,594,997	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)		7,594,997	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0043

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

Worksheet D-1

Date/Time Prepared:
9/29/2020 8:26 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	4,056,606	1,330	3,050.08	809	2,467,515
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)					15,728,551
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					25,791,063
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					757,481
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					998,555
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,756,036
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					24,035,027
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)					2,960
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,208.24
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,576,390

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0043

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

Worksheet D-1

Date/Time Prepared:
9/29/2020 8:26 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	1,303,809	17,434,841	0.074782	3,576,390	267,450	90.00
91.00 Nursing School cost	0	17,434,841	0.000000	3,576,390	0	91.00
92.00 Allied health cost	0	17,434,841	0.000000	3,576,390	0	92.00
93.00 All other Medical Education	0	17,434,841	0.000000	3,576,390	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0043	Period: From 05/01/2019 To 04/30/2020	Worksheet D-3 Date/Time Prepared: 9/29/2020 8:26 am	
Cost Center Description			Title XVIII	Hospital	PPS	
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		13,392,441		30.00
31.00	03100	INTENSIVE CARE UNIT		4,074,317		31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.107504	7,697,615	827,524	50.00
51.00	05100	RECOVERY ROOM	0.271107	905,853	245,583	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.386517	17,632	6,815	52.00
53.00	05300	ANESTHESIOLOGY	0.013193	3,467,073	45,741	53.00
53.01	05301	PAIN MANAGEMENT	0.117823	49,534	5,836	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.157958	2,223,201	351,172	54.00
54.01	05401	ULTRASOUND	0.078517	763,142	59,920	54.01
56.00	05600	RADIOISOTOPE	0.078246	431,962	33,799	56.00
57.00	05700	CT SCAN	0.033050	6,404,828	211,680	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.066276	838,647	55,582	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.143959	4,383,583	631,056	59.00
60.00	06000	LABORATORY	0.081560	11,027,500	899,403	60.00
64.00	06400	INTRAVENOUS THERAPY	0.099562	264,334	26,318	64.00
65.00	06500	RESPIRATORY THERAPY	0.278561	3,374,239	939,931	65.00
66.00	06600	PHYSICAL THERAPY	0.474295	1,089,507	516,748	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.281567	343,367	96,681	67.00
68.00	06800	SPEECH PATHOLOGY	0.670915	125,238	84,024	68.00
69.00	06900	ELECTROCARDIOLOGY	0.092964	3,175,696	295,225	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.104014	85,681	8,912	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.810036	6,649,237	5,386,121	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.398717	8,391,029	3,345,646	73.00
74.00	07400	RENAL DIALYSIS	0.491260	355,079	174,436	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	07501	GI LAB	0.117636	1,063,108	125,060	75.01
76.00	03950	DIABETIC EDUCATION	1.224488	0	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.202801	0	0	76.98
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.477930	54,031	25,823	90.00
91.00	09100	EMERGENCY	0.156760	6,566,192	1,029,316	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.544903	550,922	300,199	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	HOME INFUSION	0.258465	0	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		70,298,230	15,728,551	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00		Net charges (line 200 minus line 201)		70,298,230		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0043

Period:
From 05/01/2019
To 04/30/2020Worksheet E
Part A
Date/Time Prepared:
9/29/2020 8:26 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)			6,469,191	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			8,087,602	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)			149,728	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			178,526	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)			79.91	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)			2.04	30.00
31.00	Percentage of Medicaid patient days (see instructions)			19.30	31.00
32.00	Sum of lines 30 and 31			21.34	32.00
33.00	Allowable disproportionate share percentage (see instructions)			6.82	33.00
34.00	Disproportionate share adjustment (see instructions)			248,194	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0043	Period: From 05/01/2019 To 04/30/2020	Worksheet E Part A Date/Time Prepared: 9/29/2020 8:26 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)	899,390	1,010,165	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	377,005	587,883	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	964,888		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)	16,098,129		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	17,979,633		48.00
		Amount		
		1.00		
49.00	Total payment for inpatient operating costs (see instructions)		17,509,257	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,182,156	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)		18,691,413	59.00
60.00	Primary payer payments		16,705	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		18,674,708	61.00
62.00	Deductibles billed to program beneficiaries		1,863,796	62.00
63.00	Coinsurance billed to program beneficiaries		16,709	63.00
64.00	Allowable bad debts (see instructions)		517,211	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		336,187	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		358,170	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		17,130,390	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)		5,802	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		-1,971	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		61,486	70.93
70.94	HRR adjustment amount (see instructions)		-19,410	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0043	Period: From 05/01/2019 To 04/30/2020	Worksheet E Part A Date/Time Prepared: 9/29/2020 8:26 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)		17,176,297	71.00
71.01	Sequestration adjustment (see instructions)		343,526	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		16,835,399	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)		-2,628	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		0	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)	589,898	821,230	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	1.0065940610	1.0023278940	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	3,890	1,912	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	1.00000	0.9976	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	-1,971	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0043	Period: From 05/01/2019 To 04/30/2020	Worksheet E Part B Date/Time Prepared: 9/29/2020 8:26 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		133,354	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		38,751,890	2.00
3.00	OPPS payments		31,193,374	3.00
4.00	Outlier payment (see instructions)		519,855	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)		133,354	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		334,456	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)		334,456	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)		334,456	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		201,102	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)		133,354	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)		31,713,229	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)		6,070,565	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)		25,776,018	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)		25,776,018	30.00
31.00	Primary payer payments		3,581	31.00
32.00	Subtotal (line 30 minus line 31)		25,772,437	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)		957,003	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		622,052	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		680,295	36.00
37.00	Subtotal (see instructions)		26,394,489	37.00
38.00	MSP-LCC reconciliation amount from PS&R		15	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)		26,394,474	40.00
40.01	Sequestration adjustment (see instructions)		527,889	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		25,766,161	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)		100,424	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: 14-0043

Period:
From 05/01/2019
To 04/30/2020Worksheet E-1
Part I
Date/Time Prepared:
9/29/2020 8:26 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		16,895,078		25,829,005	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	11/18/2019	59,679	11/18/2019	62,844	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)		-59,679		-62,844	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)		16,835,399		25,766,161	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		100,424	6.01	
6.02	SETTLEMENT TO PROGRAM		2,628		0	6.02	
7.00	Total Medicare program liability (see instructions)		16,832,771		25,866,585	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: 14-0043

Period:

Worksheet E-1

Component CCN: 14-U043

From 05/01/2019
To 04/30/2020Part I
Date/Time Prepared:
9/29/2020 8:26 am

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0043

Period:
From 05/01/2019
To 04/30/2020Worksheet E-1
Part II
Date/Time Prepared:
9/29/2020 8:26 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 - SWING BEDS

Provider CCN: 14-0043

Period:

Worksheet E-2

Component CCN: 14-U043

From 05/01/2019
To 04/30/2020Date/Time Prepared:
9/29/2020 8:26 am

		Title XVIII	Swing Beds - SNF	PPS	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)		0	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)				3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		0	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		0	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		0	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		0	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		0	0	19.00
19.01	Sequestration adjustment (see instructions)		0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
20.00	Interim payments		0	0	20.00
20.01	Interim payments-PARHM				20.01
21.00	Tentative settlement (for contractor use only)		0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)				21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		0	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

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

Provider CCN: 14-0043

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

Worksheet G

Date/Time Prepared:

9/29/2020 8:26 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	49,387,371	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	17,775,394	0	0	0	4.00
5.00 Other receivable	1,207,221	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00 Inventory	5,084,284	0	0	0	7.00
8.00 Prepaid expenses	4,939,046	0	0	0	8.00
9.00 Other current assets	720,591	0	0	0	9.00
10.00 Due from other funds	125,985	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	79,239,892	0	0	0	11.00
FIXED ASSETS					
12.00 Land	2,864,606	0	0	0	12.00
13.00 Land improvements	3,742,342	0	0	0	13.00
14.00 Accumulated depreciation	-2,370,412	0	0	0	14.00
15.00 Buildings	97,660,063	0	0	0	15.00
16.00 Accumulated depreciation	-58,553,440	0	0	0	16.00
17.00 Leasehold improvements	11,395,428	0	0	0	17.00
18.00 Accumulated depreciation	-10,322,000	0	0	0	18.00
19.00 Fixed equipment	518,466	0	0	0	19.00
20.00 Accumulated depreciation	-393,063	0	0	0	20.00
21.00 Automobiles and trucks	490,517	0	0	0	21.00
22.00 Accumulated depreciation	-406,884	0	0	0	22.00
23.00 Major movable equipment	78,864,583	0	0	0	23.00
24.00 Accumulated depreciation	-57,542,073	0	0	0	24.00
25.00 Minor equipment depreciable	14,578,125	0	0	0	25.00
26.00 Accumulated depreciation	-13,121,862	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	4,288,132	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	71,692,528	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	71,138,990	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	27,531,101	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	98,670,091	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	249,602,511	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	4,851,768	0	0	0	37.00
38.00 Salaries, wages, and fees payable	10,264,207	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	3,055,000	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	0	0	0	0	43.00
44.00 Other current liabilities	17,198,574	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	35,369,549	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	6,997,971	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	71,965,074	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	78,963,045	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	114,332,594	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	135,269,917	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)	135,269,917	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	249,602,511	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0043

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

Worksheet G-1

Date/Time Prepared:
9/29/2020 8:26 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		139,483,894		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-4,213,977				2.00
3.00	Total (sum of line 1 and line 2)		135,269,917		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)		135,269,917		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		135,269,917		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0043

Period:
From 05/01/2019
To 04/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
9/29/2020 8:26 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	28,724,815		28,724,815	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	28,724,815		28,724,815	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	6,707,126		6,707,126	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)	6,707,126		6,707,126	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	35,431,941		35,431,941	17.00
18.00	Ancillary services	122,414,788	433,605,725	556,020,513	18.00
19.00	Outpatient services	12,548,868	72,564,929	85,113,797	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		1,596,179	1,596,179	22.00
23.00	AMBULANCE SERVICES	0	5,488,085	5,488,085	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIANS' PRIVATE OFFICES	246	6,304,593	6,304,839	27.00
27.01	PT/OT/ST NON-PROVIDER BASED	0	14,361,958	14,361,958	27.01
27.02	HOME INFUSION	0	1,251,899	1,251,899	27.02
27.03	PROFESSIONAL FEES	13,560,858	173,603,598	187,164,456	27.03
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	183,956,701	708,776,966	892,733,667	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		233,509,936		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	INTEREST EXPENSE	263,303			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)		263,303		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		233,246,633		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0043

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

Worksheet G-3

Date/Time Prepared:
9/29/2020 8:26 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	892,733,667	1.00
2.00	Less contractual allowances and discounts on patients' accounts	675,854,722	2.00
3.00	Net patient revenues (line 1 minus line 2)	216,878,945	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	233,246,633	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-16,367,688	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	66,545	6.00
7.00	Income from investments	3,302,799	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	172,238	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	13,023	13.00
14.00	Revenue from meals sold to employees and guests	752,990	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	2,850,839	17.00
18.00	Revenue from sale of medical records and abstracts	50,222	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	51,877	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	33,261	22.00
23.00	Governmental appropriations	200,000	23.00
24.00	CHANGE IN NET EQUITY OF AFFILIATES	-127,738	24.00
24.01	DAYCARE REVENUE	518,283	24.01
24.02	EHR REVENUE	0	24.02
24.03	MISCELLANEOUS INCOME	355,119	24.03
24.04	340B INCOME	0	24.04
24.05	COVID STIMULUS FUNDS	4,575,790	24.05
25.00	Total other income (sum of lines 6-24)	12,815,248	25.00
26.00	Total (line 5 plus line 25)	-3,552,440	26.00
27.00	DONATION EXPENSES	282,096	27.00
27.01	INTEREST EXPENSE	263,303	27.01
27.02	LOSS ON SALE OF ASSET	116,138	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	661,537	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-4,213,977	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0043

Period:

Worksheet H

HHA CCN: 14-7562

From 05/01/2019

Date/Time Prepared:

To 04/30/2020

9/29/2020 8:26 am

Home Health
Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00 Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00 Capital Related - Movable Equipment			0		0	0	2.00
3.00 Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00 Transportation	0	0	0	0	0	0	4.00
5.00 Administrative and General	178,559	0	21,031	0	172,028	371,618	5.00
HHA REIMBURSABLE SERVICES							
6.00 Skilled Nursing Care	787,076	0	0	0	0	787,076	6.00
7.00 Physical Therapy	219,781	0	0	0	0	219,781	7.00
8.00 Occupational Therapy	38,426	0	0	0	0	38,426	8.00
9.00 Speech Pathology	11,001	0	0	0	0	11,001	9.00
10.00 Medical Social Services	0	0	0	0	0	0	10.00
11.00 Home Health Aide	26,440	0	0	0	0	26,440	11.00
12.00 Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00 Drugs	0	0	0	0	0	0	13.00
14.00 DME	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00 Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00 Respiratory Therapy	0	0	0	0	0	0	16.00
17.00 Private Duty Nursing	0	0	0	0	0	0	17.00
18.00 Clinic	0	0	0	0	0	0	18.00
19.00 Health Promotion Activities	0	0	0	0	0	0	19.00
20.00 Day Care Program	0	0	0	0	0	0	20.00
21.00 Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00 Homemaker Service	0	0	0	0	0	0	22.00
23.00 All Others (specify)	0	0	0	0	0	0	23.00
23.50 Telemedicine	0	0	0	0	0	0	23.50
24.00 Total (sum of lines 1-23)	1,261,283	0	21,031	0	172,028	1,454,342	24.00
	Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00 Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00 Capital Related - Movable Equipment	0	0	0	0			2.00
3.00 Plant Operation & Maintenance	0	0	0	0			3.00
4.00 Transportation	0	0	0	0			4.00
5.00 Administrative and General	-52,790	318,828	-199	318,629			5.00
HHA REIMBURSABLE SERVICES							
6.00 Skilled Nursing Care	0	787,076	0	787,076			6.00
7.00 Physical Therapy	0	219,781	0	219,781			7.00
8.00 Occupational Therapy	0	38,426	0	38,426			8.00
9.00 Speech Pathology	0	11,001	0	11,001			9.00
10.00 Medical Social Services	0	0	0	0			10.00
11.00 Home Health Aide	0	26,440	0	26,440			11.00
12.00 Supplies (see instructions)	0	0	0	0			12.00
13.00 Drugs	0	0	0	0			13.00
14.00 DME	0	0	0	0			14.00
HHA NONREIMBURSABLE SERVICES							
15.00 Home Dialysis Aide Services	0	0	0	0			15.00
16.00 Respiratory Therapy	0	0	0	0			16.00
17.00 Private Duty Nursing	0	0	0	0			17.00
18.00 Clinic	0	0	0	0			18.00
19.00 Health Promotion Activities	0	0	0	0			19.00
20.00 Day Care Program	0	0	0	0			20.00
21.00 Home Delivered Meals Program	0	0	0	0			21.00
22.00 Homemaker Service	0	0	0	0			22.00
23.00 All Others (specify)	0	0	0	0			23.00
23.50 Telemedicine	0	0	0	0			23.50
24.00 Total (sum of lines 1-23)	-52,790	1,401,552	-199	1,401,353			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-0043

Period:

Worksheet H-1

HHA CCN: 14-7562

From 05/01/2019
To 04/30/2020Part I
Date/Time Prepared:
9/29/2020 8:26 amHome Health
Agency I

PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
			Bldgs & Fixtures	Movable Equipment				
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	318,629	0	0	0	0	318,629	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	787,076	0	0	0	0	787,076	6.00
7.00	Physical Therapy	219,781	0	0	0	0	219,781	7.00
8.00	Occupational Therapy	38,426	0	0	0	0	38,426	8.00
9.00	Speech Pathology	11,001	0	0	0	0	11,001	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	26,440	0	0	0	0	26,440	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,401,353	0	0	0	0	1,401,353	24.00
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General	318,629						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	231,625	1,018,701					6.00
7.00	Physical Therapy	64,678	284,459					7.00
8.00	Occupational Therapy	11,308	49,734					8.00
9.00	Speech Pathology	3,237	14,238					9.00
10.00	Medical Social Services	0	0					10.00
11.00	Home Health Aide	7,781	34,221					11.00
12.00	Supplies (see instructions)	0	0					12.00
13.00	Drugs	0	0					13.00
14.00	DME	0	0					14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00	Homemaker Service	0	0					22.00
23.00	All Others (specify)	0	0					23.00
23.50	Telemedicine	0	0					23.50
24.00	Total (sum of lines 1-23)		1,401,353					24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-0043

Period:

Worksheet H-1

HHA CCN: 14-7562

From 05/01/2019
To 04/30/2020Part II
Date/Time Prepared:
9/29/2020 8:26 amHome Health
Agency I

PPS

		Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Agency 1 Reconciliation	Administrative & General (ACCUM. COST)		
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)						
		1.00	2.00						3.00
	GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00	
2.00	Capital Related - Movable Equipment		0			0		2.00	
3.00	Plant Operation & Maintenance	0	0	0		0		3.00	
4.00	Transportation (see instructions)	0	0	0	0			4.00	
5.00	Administrative and General	0	0	0	0	-318,629	1,082,724	5.00	
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	0	0	0	0	0	787,076	6.00	
7.00	Physical Therapy	0	0	0	0	0	219,781	7.00	
8.00	Occupational Therapy	0	0	0	0	0	38,426	8.00	
9.00	Speech Pathology	0	0	0	0	0	11,001	9.00	
10.00	Medical Social Services	0	0	0	0	0	0	10.00	
11.00	Home Health Aide	0	0	0	0	0	26,440	11.00	
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00	
13.00	Drugs	0	0	0		0	0	13.00	
14.00	DME	0	0	0	0	0	0	14.00	
	HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	0	23.00	
23.50	Telemedicine	0	0	0	0	0	0	23.50	
24.00	Total (sum of lines 1-23)	0	0	0	0	-318,629	1,082,724	24.00	
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		318,629	25.00	
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.294285	26.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0043

Period:

Worksheet H-2

HHA CCN: 14-7562

From 05/01/2019
To 04/30/2020Part I
Date/Time Prepared:
9/29/2020 8:26 amHome Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			BLDG & FIXT	MVBLE EQUIP				
			0	1.00				
1.00	Administrative and General	0	20,961	17,904	81,414	120,279	26,754	1.00
2.00	Skilled Nursing Care	1,018,701	0	0	358,865	1,377,566	306,410	2.00
3.00	Physical Therapy	284,459	0	0	100,209	384,668	85,561	3.00
4.00	Occupational Therapy	49,734	0	0	17,520	67,254	14,959	4.00
5.00	Speech Pathology	14,238	0	0	5,016	19,254	4,283	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	34,221	0	0	12,055	46,276	10,293	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,401,353	20,961	17,904	575,079	2,015,297	448,260	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00
Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	31,494	0	20,169	0	1,544	26,236	1.00
2.00	Skilled Nursing Care	0	0	0	0	17,623	0	2.00
3.00	Physical Therapy	0	0	0	0	4,927	0	3.00
4.00	Occupational Therapy	0	0	0	0	865	0	4.00
5.00	Speech Pathology	0	0	0	0	247	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	587	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	31,494	0	20,169	0	25,793	26,236	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0043

Period:

Worksheet H-2

HHA CCN: 14-7562

From 05/01/2019
To 04/30/2020Part I
Date/Time Prepared:
9/29/2020 8:26 am

Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Home Health Agency I Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	38	0	9,636	236,150	0	236,150	1.00
2.00	Skilled Nursing Care	0	0	0	1,701,599	0	1,701,599	2.00
3.00	Physical Therapy	0	0	0	475,156	0	475,156	3.00
4.00	Occupational Therapy	0	0	0	83,078	0	83,078	4.00
5.00	Speech Pathology	0	0	0	23,784	0	23,784	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	57,156	0	57,156	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	38	0	9,636	2,576,923	0	2,576,923	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Allocated HHA A&G (see Part II)	Total HHA Costs					
		27.00	28.00					
1.00	Administrative and General							1.00
2.00	Skilled Nursing Care	171,668	1,873,267					2.00
3.00	Physical Therapy	47,936	523,092					3.00
4.00	Occupational Therapy	8,381	91,459					4.00
5.00	Speech Pathology	2,399	26,183					5.00
6.00	Medical Social Services	0	0					6.00
7.00	Home Health Aide	5,766	62,922					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
19.50	Telemedicine	0	0					19.50
20.00	Total (sum of lines 1-19) (2)	236,150	2,576,923					20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.100885						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

 Provider CCN: 14-0043
 HHA CCN: 14-7562

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

 Worksheet H-2
 Part II
 Date/Time Prepared:
 9/29/2020 8:26 am

						Home Health Agency I	9/29/2020 8:26 am PPS	
Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)		
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				OPERATION OF PLANT (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	2,326	17,692	178,559	0	120,279	2,326	1.00
2.00	Skilled Nursing Care	0	0	787,076	0	1,377,566	0	2.00
3.00	Physical Therapy	0	0	219,781	0	384,668	0	3.00
4.00	Occupational Therapy	0	0	38,426	0	67,254	0	4.00
5.00	Speech Pathology	0	0	11,001	0	19,254	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	26,440	0	46,276	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	2,326	17,692	1,261,283		2,015,297	2,326	20.00
21.00	Total cost to be allocated	20,961	17,904	575,079		448,260	31,494	21.00
22.00	Unit cost multiplier	9.011608	1.011983	0.455948		0.222429	13.539983	22.00
Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	2,326	0	100	34,741	485	1.00
2.00	Skilled Nursing Care	0	0	0	1,141	0	0	2.00
3.00	Physical Therapy	0	0	0	319	0	0	3.00
4.00	Occupational Therapy	0	0	0	56	0	0	4.00
5.00	Speech Pathology	0	0	0	16	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	38	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	2,326	0	1,670	34,741	485	20.00
21.00	Total cost to be allocated	0	20,169	0	25,793	26,236	38	21.00
22.00	Unit cost multiplier	0.000000	8.671109	0.000000	15.444910	0.755188	0.078351	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0043

Period:

Worksheet H-2

HHA CCN: 14-7562

From 05/01/2019
To 04/30/2020Part II
Date/Time Prepared:
9/29/2020 8:26 amHome Health
Agency I

PPS

Cost Center Description		PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
		15.00	16.00		
1.00	Administrative and General	0	1,596,179		1.00
2.00	Skilled Nursing Care	0	0		2.00
3.00	Physical Therapy	0	0		3.00
4.00	Occupational Therapy	0	0		4.00
5.00	Speech Pathology	0	0		5.00
6.00	Medical Social Services	0	0		6.00
7.00	Home Health Aide	0	0		7.00
8.00	Supplies (see instructions)	0	0		8.00
9.00	Drugs	0	0		9.00
10.00	DME	0	0		10.00
11.00	Home Dialysis Aide Services	0	0		11.00
12.00	Respiratory Therapy	0	0		12.00
13.00	Private Duty Nursing	0	0		13.00
14.00	Clinic	0	0		14.00
15.00	Health Promotion Activities	0	0		15.00
16.00	Day Care Program	0	0		16.00
17.00	Home Delivered Meals Program	0	0		17.00
18.00	Homemaker Service	0	0		18.00
19.00	All Others (specify)	0	0		19.00
19.50	Telemedicine	0	0		19.50
20.00	Total (sum of lines 1-19)	0	1,596,179		20.00
21.00	Total cost to be allocated	0	9,636		21.00
22.00	Unit cost multiplier	0.000000	0.006037		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0043

Period:

Worksheet H-3

HHA CCN: 14-7562

From 05/01/2019
To 04/30/2020Part I
Date/Time Prepared:
9/29/2020 8:26 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
	0	1.00	2.00	3.00	4.00	5.00	

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION

Cost Per Visit Computation

1.00	Skilled Nursing Care	2.00	1,873,267		1,873,267	4,790	391.08	1.00
2.00	Physical Therapy	3.00	523,092	0	523,092	2,071	252.58	2.00
3.00	Occupational Therapy	4.00	91,459	0	91,459	436	209.77	3.00
4.00	Speech Pathology	5.00	26,183	0	26,183	124	211.15	4.00
5.00	Medical Social Services	6.00	0	0	0	0	0.00	5.00
6.00	Home Health Aide	7.00	62,922	0	62,922	345	182.38	6.00
7.00	Total (sum of lines 1-6)		2,576,923	0	2,576,923	7,766		7.00

Program Visits

Part B

Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles		
	0	1.00	2.00	3.00	4.00	5.00	

Limitation Cost Computation

8.00	Skilled Nursing Care		99914	0	2,139		8.00
9.00	Physical Therapy		99914	0	1,047		9.00
10.00	Occupational Therapy		99914	0	238		10.00
11.00	Speech Pathology		99914	0	88		11.00
12.00	Medical Social Services		99914	0	0		12.00
13.00	Home Health Aide		99914	0	265		13.00
14.00	Total (sum of lines 8-13)			0	3,777		14.00

Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
	0	1.00	2.00	3.00	4.00	5.00	

Supplies and Drugs Cost Computations

15.00	Cost of Medical Supplies	8.00	0	17,275	17,275	21,326	0.810044	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

Cost Center Description	Part A	Part B	Part A	Part B	Part A	Part B	
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	6.00	7.00	8.00	9.00	10.00	11.00	

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION

Cost Per Visit Computation

1.00	Skilled Nursing Care	0	2,139	0	836,520		1.00
2.00	Physical Therapy	0	1,047	0	264,451		2.00
3.00	Occupational Therapy	0	238	0	49,925		3.00
4.00	Speech Pathology	0	88	0	18,581		4.00
5.00	Medical Social Services	0	0	0	0		5.00
6.00	Home Health Aide	0	265	0	48,331		6.00
7.00	Total (sum of lines 1-6)	0	3,777	0	1,217,808		7.00

Cost Center Description	6.00	7.00	8.00	9.00	10.00	11.00	
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Limitation Cost Computation

8.00	Skilled Nursing Care						8.00
9.00	Physical Therapy						9.00
10.00	Occupational Therapy						10.00
11.00	Speech Pathology						11.00
12.00	Medical Social Services						12.00
13.00	Home Health Aide						13.00
14.00	Total (sum of lines 8-13)						14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0043

Period:

Worksheet H-3

HHA CCN: 14-7562

From 05/01/2019

Part I

To 04/30/2020

Date/Time Prepared:

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Title XVIII

Home Health
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Cost Center Description		Program Covered Charges			Cost of Services	Agency 1		
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
			6.00	7.00		8.00	9.00	10.00
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	7,301	0	0	5,914	15.00
16.00	Cost of Drugs		0	0		0	0	16.00
Cost Center Description		Total Program Cost (sum of cols. 9-10)						
		12.00						
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	836,520						1.00
2.00	Physical Therapy	264,451						2.00
3.00	Occupational Therapy	49,925						3.00
4.00	Speech Pathology	18,581						4.00
5.00	Medical Social Services	0						5.00
6.00	Home Health Aide	48,331						6.00
7.00	Total (sum of lines 1-6)	1,217,808						7.00
Cost Center Description								
		12.00						
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0043

Period:

Worksheet H-3

HHA CCN: 14-7562

From 05/01/2019
To 04/30/2020Part II
Date/Time Prepared:
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Title XVIII

Home Health
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Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.474295	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.281567	0	0	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.670915	0	0	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.810036	21,326	17,275	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.398717	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

		Provider CCN: 14-0043	Period: From 05/01/2019	Worksheet H-4
		HHA CCN: 14-7562	To 04/30/2020	Part I-II
		Title XVIII	Home Health Agency I	Date/Time Prepared: 9/29/2020 8:26 am
			PPS	
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	645,445	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	50,355	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	15,345	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	2,920	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	20,211	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)	0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	734,276	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	734,276	24.00
25.00	Coinsurance billed to program patients (from your records)	0	0	25.00
26.00	Net cost (line 24 minus line 25)	0	734,276	26.00
27.00	Reimbursable bad debts (from your records)	0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	734,276	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	734,276	31.00
31.01	Sequestration adjustment (see instructions)	0	14,686	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	719,590	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED
TO PROGRAM BENEFICIARIES

Provider CCN: 14-0043

Period:

Worksheet H-5

HHA CCN: 14-7562

From 05/01/2019
To 04/30/2020Date/Time Prepared:
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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		719,590	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			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			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. H-4, Part II, column as appropriate, line 32)		0		719,590	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		719,590	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0043	Period: From 05/01/2019 To 04/30/2020	Worksheet L Parts I-III Date/Time Prepared: 9/29/2020 8:26 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,160,544	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		21,612	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)		35.45	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		1,182,156	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