

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: 14-0184	Period: From 05/01/2019 To 04/30/2020	Worksheet S Parts I-III Date/Time Prepared: 9/30/2020 10:19 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 9/30/2020	Time: 10:19 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 HEARTLAND REGIONAL MEDICAL CENTER (14-0184) 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) GAY HUFF

Officer or Administrator of Provider(s)

CFO

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	-174,309	65,222	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
200.00	Total	0	-174,309	65,222	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: 14-0184		Period: From 05/01/2019 To 04/30/2020		Worksheet S-2 Part I Date/Time Prepared: 9/30/2020 10:19 am		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 917 WEST MAIN ST			PO Box:				1.00		
2.00	City: MARION			State: IL		Zip Code: 62959		County: WILLIAMSON		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	
								XIX		
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		HEARTLAND REGIONAL MEDICAL CENTER	140184	16060	1	07/01/1996	N	P	O
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		HEARTLAND REGIONAL MEDICAL CENTER	14U184	16060		03/23/1999	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									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC									
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						05/01/2019	04/30/2020		
21.00	Type of Control (see instructions)						4			
							1.00	2.00		
							2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y			
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
				1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			270	219	0	10	774	12	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0184

Period:
From 05/01/2019
To 04/30/2020Worksheet S-2
Part I
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		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
						Urban/Rural S	Date of Geogr	
						1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
						Beginning:	Ending:	
						1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
						Y/N	Y/N	
						1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
						V	XVIII	XIX
						1.00	2.00	3.00
Prospective Payment System (PPS)-Capital								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals								
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		
					NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
					1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.					N		60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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Period:
From 05/01/2019
To 04/30/2020Worksheet S-2
Part I
Date/Time Prepared:
9/30/2020 10:19 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		
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.						
64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			1.00	2.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
			1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS					
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0
	Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0

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			1.00				
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N 80.00			
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N 81.00			
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N 85.00			
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N 86.00			
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N 87.00			
			V	XIX			
			1.00	2.00			
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N Y 90.00			
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N N 91.00			
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N 92.00			
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N N 93.00			
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N N 94.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00 0.00 95.00			
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N N 96.00			
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00 0.00 97.00			
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y Y 98.00			
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y Y 98.01			
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y Y 98.02			
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N N 98.03			
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N N 98.04			
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y Y 98.05			
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y Y 98.06			
Rural Providers							
105.00	Does this hospital qualify as a CAH?			N 105.00			
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00			
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00			
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N 108.00			
			Physical	Occupational	Speech	Respiratory	
			1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			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: 14-0184	Period: From 05/01/2019 To 04/30/2020	Worksheet S-2 Part I Date/Time Prepared: 9/30/2020 10:19 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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:	183,843	343,264	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0776	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0184		Period: From 05/01/2019 To 04/30/2020		Worksheet S-2 Part I Date/Time Prepared: 9/30/2020 10:19 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: QUORUM HEALTH		Contractor's Name: WISCONSIN PHYSICIAN SERVICES		Contractor's Number: 10101		141.00		
142.00	Street: 1573 MALLORY LANE		PO Box:				142.00		
143.00	City: BRENTWOOD		State: TN		Zip Code: 37027		143.00		
								1.00	
144.00 Are provider based physicians' costs included in Worksheet A?								Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					Y		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					N		146.00	
								1.00	
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital			N	N	N	N		155.00
156.00	Subprovider - IPF			N	N	N	N		156.00
157.00	Subprovider - IRF			N	N	N	N		157.00
158.00	SUBPROVIDER								158.00
159.00	SNF			N	N	N	N		159.00
160.00	HOME HEALTH AGENCY			N	N	N	N		160.00
161.00	CMHC				N	N	N		161.00
								1.00	
Multicampus									
165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00
				Name	County	State	Zip Code	CBSA	FTE/Campus
				0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)									168.00
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								9.99	169.00
						Beginning	Ending		
						1.00	2.00		
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)									170.00
						1.00	2.00		
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)								N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0184		Period: From 05/01/2019 To 04/30/2020		Worksheet S-2 Part II Date/Time Prepared: 9/30/2020 10:19 am	
		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				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N					4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	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	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	09/16/2020	Y	09/16/2020		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0184	Period: From 05/01/2019 To 04/30/2020	Worksheet S-2 Part II Date/Time Prepared: 9/30/2020 10:19 am
		Description	Y/N	Y/N
		0	1.00	3.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N	33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		Y	12/31/2019
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N	40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LUCIE	GREENE	41.00
42.00	Enter the employer/company name of the cost report preparer.	QUORUM HEALTH CORP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-221-3747	LUCIE_GREENE@QUORUMHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0184

Period:
From 05/01/2019
To 04/30/2020Worksheet S-2
Part II
Date/Time Prepared:
9/30/2020 10:19 am

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR, REIMBURSEMENT	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0184

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part I
Date/Time Prepared:
9/30/2020 10:19 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	76	27,816	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)		76	27,816	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	18	6,588	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)		94	34,404	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						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)		94			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: 14-0184

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part I
Date/Time Prepared:
9/30/2020 10:19 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,683	199	6,347			1.00
2.00	HMO and other (see instructions)	626	1,015				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,683	199	6,347			7.00
8.00	INTENSIVE CARE UNIT	460	51	973			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		20	84			13.00
14.00	Total (see instructions)	4,143	270	7,404	0.00	282.21	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	282.21	27.00
28.00	Observation Bed Days		0	2,153			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	14			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: 14-0184

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part I
Date/Time Prepared:
9/30/2020 10:19 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	1,334	92	2,511	1.00
2.00 HMO and other (see instructions)			0	295		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	1,334	92	2,511	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0184

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part II
Date/Time Prepared:
9/30/2020 10:19 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	20,262,564	0	20,262,564	586,999.00	34.52
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		115,474	7,802	123,276	3,940.00	31.29
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		421,390	0	421,390	11,600.00	36.33
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		79,750	0	79,750	542.00	147.14
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		1,218,253	0	1,218,253	18,827.00	64.71
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		4,986,770	0	4,986,770		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		33,095	0	33,095		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0184

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part II
Date/Time Prepared:
9/30/2020 10:19 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	262,897	0	262,897	7,462.00	35.23	26.00
27.00	Administrative & General	5.00	2,884,422	-87,015	2,797,407	80,495.00	34.75	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	332,002	0	332,002	11,208.00	29.62	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,264,377	0	1,264,377	28,150.00	44.92	38.00
39.00	Central Services and Supply	14.00	231,348	0	231,348	12,128.00	19.08	39.00
40.00	Pharmacy	15.00	1,194,021	0	1,194,021	25,750.00	46.37	40.00
41.00	Medical Records & Medical Records Library	16.00	166,601	0	166,601	8,316.00	20.03	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: 14-0184

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part III
Date/Time Prepared:
9/30/2020 10:19 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)	20,262,564	0	20,262,564	586,999.00	34.52	1.00
2.00	Excluded area salaries (see instructions)	115,474	7,802	123,276	3,940.00	31.29	2.00
3.00	Subtotal salaries (line 1 minus line 2)	20,147,090	-7,802	20,139,288	583,059.00	34.54	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,719,393	0	1,719,393	30,969.00	55.52	4.00
5.00	Subtotal wage-related costs (see inst.)	4,986,770	0	4,986,770	0.00	24.76	5.00
6.00	Total (sum of lines 3 thru 5)	26,853,253	-7,802	26,845,451	614,028.00	43.72	6.00
7.00	Total overhead cost (see instructions)	6,335,668	-87,015	6,248,653	173,509.00	36.01	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0184

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part IV
Date/Time Prepared:
9/30/2020 10:19 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	303,234	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	2,899,394	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	24,027	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	12,775	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	-745	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	8,754	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	182,050	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	1,187,253	17.00
18.00	Medicare Taxes - Employers Portion Only	277,664	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	115,041	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,009,447	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: 14-0184

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part V
Date/Time Prepared:
9/30/2020 10:19 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	421,390	5,009,447	1.00
2.00	Hospital	421,390	5,009,447	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			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0184	Period: From 05/01/2019 To 04/30/2020	Worksheet S-10 Date/Time Prepared: 9/30/2020 10:19 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)		0.110441	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		899,618	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		5,545,357	5.00	
6.00	Medicaid charges		21,527,105	6.00	
7.00	Medicaid cost (line 1 times line 6)		2,377,475	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)		0	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		0	9.00	
10.00	Stand-alone CHIP charges		0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00	
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	4,038,055	0	4,038,055	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	445,967	0	445,967	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	445,967	0	445,967	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)		8,229,856	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		531,838	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		818,213	27.01	
28.00	Non-Medicare bad debt expense (see instructions)		7,411,643	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,104,924	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,550,891	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,550,891	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0184

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

Worksheet A

Date/Time Prepared:
9/30/2020 10:19 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,341,669	1,341,669	1,285,761	2,627,430	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,653,433	2,653,433	2,338,398	4,991,831	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	262,897	88,849	351,746	3,472,251	3,823,997	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,884,422	20,385,366	23,269,788	-6,058,866	17,210,922	5.00
7.00	00700	OPERATION OF PLANT	332,002	2,295,982	2,627,984	-426	2,627,558	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	232,865	232,865	0	232,865	8.00
9.00	00900	HOUSEKEEPING	0	1,171,162	1,171,162	0	1,171,162	9.00
10.00	01000	DIETARY	0	1,443,356	1,443,356	-262,641	1,180,715	10.00
11.00	01100	CAFETERIA	0	0	0	262,641	262,641	11.00
13.00	01300	NURSING ADMINISTRATION	1,264,377	229,976	1,494,353	-2,367	1,491,986	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	231,348	5,575,382	5,806,730	-5,228,326	578,404	14.00
15.00	01500	PHARMACY	1,194,021	2,322,177	3,516,198	-2,108,311	1,407,887	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	166,601	444,566	611,167	0	611,167	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,420,295	2,310,943	4,731,238	-49,333	4,681,905	30.00
31.00	03100	INTENSIVE CARE UNIT	1,410,882	538,391	1,949,273	-3,477	1,945,796	31.00
43.00	04300	NURSERY	59,484	5,471	64,955	40,866	105,821	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,041,358	3,933,730	5,975,088	-118,794	5,856,294	50.00
51.00	05100	RECOVERY ROOM	550,691	48,692	599,383	-599,383	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	162,952	14,030	176,982	-10,673	166,309	52.00
53.00	05300	ANESTHESIOLOGY	0	3,150,792	3,150,792	-2,502	3,148,290	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,179,812	1,412,689	2,592,501	-319,977	2,272,524	54.00
54.01	05401	ULTRASOUND	121,604	140,676	262,280	0	262,280	54.01
56.00	05600	RADIOISOTOPE	223,256	307,098	530,354	0	530,354	56.00
57.00	05700	CT SCAN	332,015	82,162	414,177	0	414,177	57.00
58.00	05800	MRI	105,759	9,689	115,448	0	115,448	58.00
60.00	06000	LABORATORY	1,096,191	1,712,471	2,808,662	-354,524	2,454,138	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	334,376	334,376	62.00
65.00	06500	RESPIRATORY THERAPY	558,194	217,427	775,621	-98,824	676,797	65.00
66.00	06600	PHYSICAL THERAPY	533,549	63,726	597,275	27,114	624,389	66.00
67.00	06700	OCCUPATIONAL THERAPY	134,218	11,073	145,291	53,090	198,381	67.00
68.00	06800	SPEECH PATHOLOGY	109,547	8,331	117,878	-80,254	37,674	68.00
69.00	06900	ELECTROCARDIOLOGY	1,076,782	1,308,226	2,385,008	-214,796	2,170,212	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,845,095	2,845,095	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,469,879	2,469,879	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,007,558	2,007,558	73.00
74.00	07400	RENAL DIALYSIS	0	336,776	336,776	0	336,776	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	232,960	232,960	0	232,960	76.01
76.03	03951	WOUND CARE	91,472	25,337	116,809	-5,976	110,833	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	1,603,361	2,565,503	4,168,864	143,332	4,312,196	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	79,213	104,695	183,908	-183,908	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,226,303	56,725,671	76,951,974	-422,947	76,529,027	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,814	2,814	0	2,814	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	36,261	4,616	40,877	0	40,877	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	0	422,947	422,947	194.01
194.02	07952	UNUSED SPACE	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	20,262,564	56,733,101	76,995,665	0	76,995,665	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0184

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

Worksheet A

Date/Time Prepared:
9/30/2020 10:19 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	380,096	3,007,526	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-709,636	4,282,195	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-318	3,823,679	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-5,493,410	11,717,512	5.00
7.00	00700	OPERATION OF PLANT	-11,273	2,616,285	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	232,865	8.00
9.00	00900	HOUSEKEEPING	0	1,171,162	9.00
10.00	01000	DIETARY	0	1,180,715	10.00
11.00	01100	CAFETERIA	-193,342	69,299	11.00
13.00	01300	NURSING ADMINISTRATION	-1,850	1,490,136	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	578,404	14.00
15.00	01500	PHARMACY	0	1,407,887	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-328	610,839	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,781,826	2,900,079	30.00
31.00	03100	INTENSIVE CARE UNIT	-167,384	1,778,412	31.00
43.00	04300	NURSERY	0	105,821	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-291,378	5,564,916	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	166,309	52.00
53.00	05300	ANESTHESIOLOGY	-3,034,725	113,565	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-294,832	1,977,692	54.00
54.01	05401	ULTRASOUND	0	262,280	54.01
56.00	05600	RADIOISOTOPE	0	530,354	56.00
57.00	05700	CT SCAN	0	414,177	57.00
58.00	05800	MRI	0	115,448	58.00
60.00	06000	LABORATORY	0	2,454,138	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	334,376	62.00
65.00	06500	RESPIRATORY THERAPY	0	676,797	65.00
66.00	06600	PHYSICAL THERAPY	0	624,389	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	198,381	67.00
68.00	06800	SPEECH PATHOLOGY	0	37,674	68.00
69.00	06900	ELECTROCARDIOLOGY	-117,069	2,053,143	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,845,095	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,469,879	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,007,558	73.00
74.00	07400	RENAL DIALYSIS	0	336,776	74.00
76.00	03020	ACUPUNCTURE	0	0	76.00
76.01	03610	SLEEP LAB	0	232,960	76.01
76.03	03951	WOUND CARE	0	110,833	76.03
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-1,959,227	2,352,969	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-13,676,502	62,852,525	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,814	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	SENIOR CIRCLE	0	40,877	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	194.00
194.01	07953	MARKETING	0	422,947	194.01
194.02	07952	UNUSED SPACE	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-13,676,502	63,319,163	200.00

RECLASSIFICATIONS

Provider CCN: 14-0184

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

Worksheet A-6

Date/Time Prepared:
9/30/2020 10:19 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,472,251		1.00
	0		0	3,472,251		
	B - OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	25,795		1.00
	0		0	25,795		
	C - RENTAL AND LEASES					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,331,790		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
	0		0	2,331,790		
	D - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	135,996		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,149,765		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,608		3.00
	0		0	1,292,369		
	E - MARKETING DEPARTMENT					
1.00	MARKETING	194.01	87,015	335,932		1.00
	0		87,015	335,932		
	F - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,819,300		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,469,879		2.00
	0		0	5,289,179		
	G - DRUGS/IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,007,558		1.00
	0		0	2,007,558		
	H - LABOR AND DELIVERY COSTS					
1.00	NURSERY	43.00	26,247	14,619		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	13,789		2.00
	0		26,247	28,408		
	I - PT, OT AND SP COST					
1.00	PHYSICAL THERAPY	66.00	30,516	0		1.00
2.00	OCCUPATIONAL THERAPY	67.00	44,997	8,093		2.00
	0		75,513	8,093		
	K - MISCELLANEOUS DEPARTMENTS					
1.00	OPERATING ROOM	50.00	550,691	48,692		1.00
2.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	58,429	275,947		2.00
3.00	EMERGENCY	91.00	79,213	104,695		3.00
	0		688,333	429,334		
	M - PORTION OF DIETARY COST TO CAFETERIA					
1.00	CAFETERIA	11.00	0	262,641		1.00
	0		0	262,641		
500.00	Grand Total: Increases		877,108	15,483,350		500.00

RECLASSIFICATIONS

Provider CCN: 14-0184

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

Worksheet A-6

Date/Time Prepared:
9/30/2020 10:19 am

	Decreases						9/30/2020 10:19 am
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,472,251	0		1.00
	0		0	3,472,251			
	B - OXYGEN COSTS						
1.00	RESPIRATORY THERAPY	65.00	0	25,795	0		1.00
	0		0	25,795			
	C - RENTAL AND LEASES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	871,299	10		1.00
2.00	OPERATION OF PLANT	7.00	0	426	0		2.00
3.00	NURSING ADMINISTRATION	13.00	0	2,367	0		3.00
4.00	PHARMACY	15.00	0	100,753	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	19,140	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	3,477	0		6.00
7.00	OPERATING ROOM	50.00	0	657,324	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	2,502	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	319,977	0		9.00
10.00	LABORATORY	60.00	0	20,148	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	73,029	0		11.00
12.00	ELECTROCARDIOLOGY	69.00	0	214,796	0		12.00
13.00	WOUND CARE	76.03	0	5,976	0		13.00
14.00	EMERGENCY	91.00	0	40,576	0		14.00
	0		0	2,331,790			
	D - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,292,369	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	0		0	1,292,369			
	E - MARKETING DEPARTMENT						
1.00	ADMINISTRATIVE & GENERAL	5.00	87,015	335,932	0		1.00
	0		87,015	335,932			
	F - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	5,228,326	0		1.00
2.00	OPERATING ROOM	50.00	0	60,853	0		2.00
	0		0	5,289,179			
	G - DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	2,007,558	0		1.00
	0		0	2,007,558			
	H - LABOR AND DELIVERY COSTS						
1.00	ADULTS & PEDIATRICS	30.00	1,785	28,408	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	24,462	0	0		2.00
	0		26,247	28,408			
	I - PT, OT AND SP COST						
1.00	PHYSICAL THERAPY	66.00	0	3,402	0		1.00
2.00	SPEECH PATHOLOGY	68.00	75,513	4,691	0		2.00
	0		75,513	8,093			
	K - MISCELLANEOUS DEPARTMENTS						
1.00	RECOVERY ROOM	51.00	550,691	48,692	0		1.00
2.00	LABORATORY	60.00	58,429	275,947	0		2.00
3.00	AMBULANCE SERVICES	95.00	79,213	104,695	0		3.00
	0		688,333	429,334			
	M - PORTION OF DIETARY COST TO CAFETERIA						
1.00	DIETARY	10.00	0	262,641	0		1.00
	0		0	262,641			
500.00	Grand Total: Decreases		877,108	15,483,350			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0184

Period:
From 05/01/2019
To 04/30/2020Worksheet A-7
Part I
Date/Time Prepared:
9/30/2020 10:19 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	1,393,860	0	0	0	0	1.00	
2.00	Land Improvements	564,833	257,721	0	257,721	0	2.00	
3.00	Buildings and Fixtures	53,674,470	32,989	0	32,989	0	3.00	
4.00	Building Improvements	22,780,744	829,789	0	829,789	527,056	4.00	
5.00	Fixed Equipment	2,492,017	123,708	0	123,708	1,424	5.00	
6.00	Movable Equipment	3,348,370	128,279	0	128,279	3,420	6.00	
7.00	HIT designated Assets	6,509,483	3,012	0	3,012	21,473	7.00	
8.00	Subtotal (sum of lines 1-7)	90,763,777	1,375,498	0	1,375,498	553,373	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	90,763,777	1,375,498	0	1,375,498	553,373	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,393,860	0				1.00	
2.00	Land Improvements	822,554	0				2.00	
3.00	Buildings and Fixtures	53,707,459	0				3.00	
4.00	Building Improvements	23,083,477	0				4.00	
5.00	Fixed Equipment	2,614,301	0				5.00	
6.00	Movable Equipment	3,473,229	0				6.00	
7.00	HIT designated Assets	6,491,022	0				7.00	
8.00	Subtotal (sum of lines 1-7)	91,585,902	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	91,585,902	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0184

Period:
From 05/01/2019
To 04/30/2020Worksheet A-7
Part II
Date/Time Prepared:
9/30/2020 10:19 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	1,341,669	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,653,433	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,995,102	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
		PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2					
1.00	CAP REL COSTS-BLDG & FIXT	0	1,341,669				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,653,433				2.00
3.00	Total (sum of lines 1-2)	0	3,995,102				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0184

Period:
From 05/01/2019
To 04/30/2020Worksheet A-7
Part III
Date/Time Prepared:
9/30/2020 10:19 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	79,007,350	0	79,007,350	0.862658	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	12,578,552	0	12,578,552	0.137342	0	2.00
3.00	Total (sum of lines 1-2)	91,585,902	0	91,585,902	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,576,972	-3,865	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,923,877	2,331,790	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,500,849	2,327,925	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	148,658	135,996	1,149,765	0	3,007,526	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	19,920	6,608	0	0	4,282,195	2.00
3.00	Total (sum of lines 1-2)	168,578	142,604	1,149,765	0	7,289,721	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0184

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

Worksheet A-8

Date/Time Prepared:
9/30/2020 10:19 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-3,865	CAP REL COSTS-BLDG & FIXT	1.00	10	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-27,563	ADMINISTRATIVE & GENERAL	5.00	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	-7,664,627			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	589,381			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-193,342	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-328	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)	B	0	NURSING ADMINISTRATION	13.00	0	19.00
20.00	Vending machines	B	0	ADMINISTRATIVE & GENERAL	5.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	235,303	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-722,294	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELLANEOUS REVENUE	B	-1,117	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0184

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

Worksheet A-8

Date/Time Prepared:
9/30/2020 10:19 am

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33.01 INSERVICE EDUCATION	B	-1,150	NURSING ADMINISTRATION	13.00	0	33.01
33.02 PATIENT PHONE SALARIES AND WAGES	A	-1,272	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03 PATIENT PHONE BENEFIT EXPENSE	A	-318	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.03
33.04 PATIENT PHONE DEPRECIATION EXPENSE	A	-6,890	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.04
33.05 PATIENT TV DEPRECIATION EXPENSE	A	-372	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.05
33.06 MARKETING EXPENSES	A	-145,051	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07 EMPLOYEE GIFTS	A	-3,830	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08 PHYSICIAN RECRUITING	A	-118,056	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09 LOBBYING EXPENSE	A	-27,561	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10 CHARITABLE CONTRIBUTIONS	A	-40,282	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11 VOLUNTEERS	A	-90	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12 ILLINOIS PROVIDER TAX	A	-5,477,069	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13 CRNA COST	A	7,186	ANESTHESIOLOGY	53.00	0	33.13
33.15 MISC NON-PATIENT REV	B	-20	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16 SPECIAL EVENTS	A	-19,469	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.18 LATE CHARGES	A	-41,833	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19 PATIENT TV CABLE EXPENSE	A	-11,273	OPERATION OF PLANT	7.00	0	33.19
33.20 TRAINING REVENUE	B	-700	NURSING ADMINISTRATION	13.00	0	33.20
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-13,676,502				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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

Provider CCN: 14-0184

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

Worksheet A-8-1

Date/Time Prepared:
9/30/2020 10:19 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00		5.00	ADMINISTRATIVE & GENERAL	5,810	0	1.00
2.00		5.00	ADMINISTRATIVE & GENERAL	607,443	0	2.00
3.00		1.00	CAP REL COSTS-BLDG & FIXT	148,658	0	3.00
4.00		2.00	CAP REL COSTS-MVBLE EQUIP	19,920	0	4.00
4.01		5.00	ADMINISTRATIVE & GENERAL	1,070,570	0	4.01
4.02		5.00	ADMINISTRATIVE & GENERAL	0	2,483,420	4.02
4.03		5.00	ADMINISTRATIVE & GENERAL	527,107	-693,293	4.03
5.00				2,379,508	1,790,127	5.00
	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.					

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

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office		
	1.00	2.00	3.00	Name	Percentage of Ownership	5.00

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

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

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

6.00	B	QUORUM HEALTH C	100.00	QUORUM HEALTH C	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-0184

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

Worksheet A-8-1

Date/Time Prepared:
9/30/2020 10:19 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	5,810	0		1.00
2.00	607,443	0		2.00
3.00	148,658	11		3.00
4.00	19,920	11		4.00
4.01	1,070,570	0		4.01
4.02	-2,483,420	0		4.02
4.03	1,220,400	0		4.03
5.00	589,381			5.00

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

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

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

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

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

6.00	HOSPITAL CORPOR		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0184

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

Worksheet A-8-2

Date/Time Prepared:
9/30/2020 10:19 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	11,000	11,000	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,781,826	1,781,826	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	167,384	167,384	0	0	0	3.00
4.00	50.00	OPERATING ROOM	291,378	291,378	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	3,041,911	3,041,911	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	294,832	294,832	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	117,069	117,069	0	0	0	7.00
8.00	91.00	EMERGENCY	1,959,227	1,959,227	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			7,664,627	7,664,627	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	11,000		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,781,826		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	167,384		3.00
4.00	50.00	OPERATING ROOM	0	0	0	291,378		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	3,041,911		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	294,832		6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	117,069		7.00
8.00	91.00	EMERGENCY	0	0	0	1,959,227		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	7,664,627		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0184

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part I
Date/Time Prepared:
9/30/2020 10:19 am

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	3,007,526	3,007,526				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,282,195		4,282,195			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,823,679	15,436	21,978	3,861,093		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,717,512	304,696	433,834	540,059	12,996,101	5.00
7.00	00700	OPERATION OF PLANT	2,616,285	653,658	930,692	64,096	4,264,731	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	232,865	6,338	9,024	0	248,227	8.00
9.00	00900	HOUSEKEEPING	1,171,162	17,187	24,471	0	1,212,820	9.00
10.00	01000	DIETARY	1,180,715	46,832	66,681	0	1,294,228	10.00
11.00	01100	CAFETERIA	69,299	52,927	75,359	0	197,585	11.00
13.00	01300	NURSING ADMINISTRATION	1,490,136	72,963	103,887	244,098	1,911,084	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	578,404	29,786	42,410	44,664	695,264	14.00
15.00	01500	PHARMACY	1,407,887	27,090	38,571	230,515	1,704,063	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	610,839	43,829	62,405	32,164	749,237	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,900,079	472,691	673,030	466,913	4,512,713	30.00
31.00	03100	INTENSIVE CARE UNIT	1,778,412	156,456	222,766	272,382	2,430,016	31.00
43.00	04300	NURSERY	105,821	2,083	2,966	16,551	127,421	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,564,916	262,323	373,503	500,416	6,701,158	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	166,309	5,022	7,150	26,737	205,218	52.00
53.00	05300	ANESTHESIOLOGY	113,565	7,603	10,825	0	131,993	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,977,692	93,153	132,634	227,772	2,431,251	54.00
54.01	05401	ULTRASOUND	262,280	26,655	37,953	23,477	350,365	54.01
56.00	05600	RADIOISOTOPE	530,354	8,830	12,572	43,101	594,857	56.00
57.00	05700	CT SCAN	414,177	15,359	21,869	64,098	515,503	57.00
58.00	05800	MRI	115,448	16,318	23,234	20,418	175,418	58.00
60.00	06000	LABORATORY	2,454,138	60,543	86,203	200,348	2,801,232	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	334,376	3,220	4,585	11,280	353,461	62.00
65.00	06500	RESPIRATORY THERAPY	676,797	13,864	19,740	107,764	818,165	65.00
66.00	06600	PHYSICAL THERAPY	624,389	83,633	119,079	108,897	935,998	66.00
67.00	06700	OCCUPATIONAL THERAPY	198,381	2,108	3,002	34,599	238,090	67.00
68.00	06800	SPEECH PATHOLOGY	37,674	1,188	1,692	6,571	47,125	68.00
69.00	06900	ELECTROCARDIOLOGY	2,053,143	53,541	76,233	207,881	2,390,798	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,845,095	0	0	0	2,845,095	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,469,879	0	0	0	2,469,879	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,007,558	0	0	0	2,007,558	73.00
74.00	07400	RENAL DIALYSIS	336,776	4,268	6,077	0	347,121	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	232,960	30,105	42,865	0	305,930	76.01
76.03	03951	WOUND CARE	110,833	35,958	51,198	17,659	215,648	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	2,352,969	121,878	173,534	324,834	2,973,215	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
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	62,852,525	2,747,541	3,912,022	3,837,294	62,198,568	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,638	12,299	0	20,937	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,814	168,672	240,160	0	411,646	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	40,877	3,182	4,530	7,000	55,589	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	422,947	0	0	16,799	439,746	194.01
194.02	07952	UNUSED SPACE	0	79,493	113,184	0	192,677	194.02
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	63,319,163	3,007,526	4,282,195	3,861,093	63,319,163	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0184

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part I
Date/Time Prepared:
9/30/2020 10:19 am

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,996,101					5.00
7.00	00700	OPERATION OF PLANT	1,101,380	5,366,111				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	64,105	16,723	329,055			8.00
9.00	00900	HOUSEKEEPING	313,214	45,348	0	1,571,382		9.00
10.00	01000	DIETARY	334,238	123,569	0	38,116	1,790,151	10.00
11.00	01100	CAFETERIA	51,027	139,651	0	43,077	0	11.00
13.00	01300	NURSING ADMINISTRATION	493,543	192,517	0	59,384	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	179,554	78,592	0	24,242	0	14.00
15.00	01500	PHARMACY	440,079	71,478	0	22,048	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	193,493	115,645	0	35,672	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,165,422	1,247,216	128,991	384,715	1,359,178	30.00
31.00	03100	INTENSIVE CARE UNIT	627,559	412,817	30,603	127,337	203,100	31.00
43.00	04300	NURSERY	32,907	5,496	0	1,695	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,730,613	692,152	38,170	213,501	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52,998	13,250	0	4,087	0	52.00
53.00	05300	ANESTHESIOLOGY	34,088	20,061	0	6,188	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	627,878	245,788	28,628	75,816	0	54.00
54.01	05401	ULTRASOUND	90,483	70,331	0	21,694	0	54.01
56.00	05600	RADIOISOTOPE	153,624	23,298	0	7,186	0	56.00
57.00	05700	CT SCAN	133,130	40,526	0	12,501	0	57.00
58.00	05800	MRI	45,302	43,055	0	13,281	0	58.00
60.00	06000	LABORATORY	723,427	159,746	0	49,275	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	91,282	8,496	0	2,621	0	62.00
65.00	06500	RESPIRATORY THERAPY	211,294	36,582	0	11,284	0	65.00
66.00	06600	PHYSICAL THERAPY	241,724	220,670	12,833	68,068	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	61,487	5,563	0	1,716	0	67.00
68.00	06800	SPEECH PATHOLOGY	12,170	3,136	0	967	0	68.00
69.00	06900	ELECTROCARDIOLOGY	617,431	141,269	17,768	43,576	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	734,754	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	637,854	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	518,458	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	89,645	11,261	0	3,474	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	79,007	79,435	4,606	24,502	0	76.01
76.03	03951	WOUND CARE	55,692	94,876	1,974	29,265	0	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	767,842	321,582	65,482	99,195	79,693	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,706,704	4,680,129	329,055	1,424,483	1,641,971	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,407	22,792	0	7,030	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	106,309	445,049	0	137,279	148,180	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	14,356	8,395	0	2,590	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	113,566	0	0	0	0	194.01
194.02	07952	UNUSED SPACE	49,759	209,746	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)	12,996,101	5,366,111	329,055	1,571,382	1,790,151	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0184

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part I
Date/Time Prepared:
9/30/2020 10:19 am

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	431,340					11.00
13.00	01300	NURSING ADMINISTRATION	24,885	2,681,413				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,723	0	988,375			14.00
15.00	01500	PHARMACY	22,770	0	6,073	2,266,511		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,357	0	1,186	0	1,102,590	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	67,243	539,649	19,648	0	66,540	30.00
31.00	03100	INTENSIVE CARE UNIT	30,752	314,814	16,657	0	10,881	31.00
43.00	04300	NURSERY	1,269	19,129	8	0	368	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	67,372	578,367	231,486	0	182,515	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,409	30,901	29	0	471	52.00
53.00	05300	ANESTHESIOLOGY	0	0	9,390	0	33,137	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,961	263,255	2,714	0	25,565	54.00
54.01	05401	ULTRASOUND	2,814	27,134	292	0	9,282	54.01
56.00	05600	RADIOISOTOPE	3,568	49,816	595	0	28,691	56.00
57.00	05700	CT SCAN	10,171	74,084	3,642	0	72,271	57.00
58.00	05800	MRI	1,894	23,598	60	0	12,619	58.00
60.00	06000	LABORATORY	42,671	0	87,273	0	195,676	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,692	0	0	0	3,980	62.00
65.00	06500	RESPIRATORY THERAPY	15,818	124,552	7,335	0	28,443	65.00
66.00	06600	PHYSICAL THERAPY	13,114	0	1,389	0	22,844	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,237	0	0	0	7,258	67.00
68.00	06800	SPEECH PATHOLOGY	2,115	0	0	0	1,378	68.00
69.00	06900	ELECTROCARDIOLOGY	27,975	240,266	15,182	0	111,281	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	269,493	0	25,860	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	274,931	0	73,476	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,266,511	70,818	73.00
74.00	07400	RENAL DIALYSIS	0	0	476	0	4,693	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	657	0	2,960	76.01
76.03	03951	WOUND CARE	2,225	20,410	1,120	0	494	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	35,829	375,438	38,697	0	111,089	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	427,864	2,681,413	988,333	2,266,511	1,102,590	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	1,692	0	42	0	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	1,784	0	0	0	0	194.01
194.02	07952	UNUSED SPACE	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)	431,340	2,681,413	988,375	2,266,511	1,102,590	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0184

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part I
Date/Time Prepared:
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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	9,491,315	0	9,491,315	30.00
31.00	03100	INTENSIVE CARE UNIT	4,204,536	0	4,204,536	31.00
43.00	04300	NURSERY	188,293	0	188,293	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,435,334	0	10,435,334	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	309,363	0	309,363	52.00
53.00	05300	ANESTHESIOLOGY	234,857	0	234,857	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,730,856	0	3,730,856	54.00
54.01	05401	ULTRASOUND	572,395	0	572,395	54.01
56.00	05600	RADIOISOTOPE	861,635	0	861,635	56.00
57.00	05700	CT SCAN	861,828	0	861,828	57.00
58.00	05800	MRI	315,227	0	315,227	58.00
60.00	06000	LABORATORY	4,059,300	0	4,059,300	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	461,532	0	461,532	62.00
65.00	06500	RESPIRATORY THERAPY	1,253,473	0	1,253,473	65.00
66.00	06600	PHYSICAL THERAPY	1,516,640	0	1,516,640	66.00
67.00	06700	OCCUPATIONAL THERAPY	317,351	0	317,351	67.00
68.00	06800	SPEECH PATHOLOGY	66,891	0	66,891	68.00
69.00	06900	ELECTROCARDIOLOGY	3,605,546	0	3,605,546	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,875,202	0	3,875,202	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,456,140	0	3,456,140	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,863,345	0	4,863,345	73.00
74.00	07400	RENAL DIALYSIS	456,670	0	456,670	74.00
76.00	03020	ACUPUNCTURE	0	0	0	76.00
76.01	03610	SLEEP LAB	497,097	0	497,097	76.01
76.03	03951	WOUND CARE	421,704	0	421,704	76.03
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,868,062	0	4,868,062	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	60,924,592	0	60,924,592	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	56,166	0	56,166	190.00
191.00	19100	RESEARCH	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,248,463	0	1,248,463	192.00
193.00	19300	NONPAID WORKERS	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	82,664	0	82,664	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	194.00
194.01	07953	MARKETING	555,096	0	555,096	194.01
194.02	07952	UNUSED SPACE	452,182	0	452,182	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)	63,319,163	0	63,319,163	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0184

Period:
From 05/01/2019
To 04/30/2020Worksheet B
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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	15,436	21,978	37,414	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	304,696	433,834	738,530	5.00
7.00	00700	OPERATION OF PLANT	0	653,658	930,692	1,584,350	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,338	9,024	15,362	8.00
9.00	00900	HOUSEKEEPING	0	17,187	24,471	41,658	9.00
10.00	01000	DIETARY	0	46,832	66,681	113,513	10.00
11.00	01100	CAFETERIA	0	52,927	75,359	128,286	11.00
13.00	01300	NURSING ADMINISTRATION	0	72,963	103,887	176,850	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	29,786	42,410	72,196	14.00
15.00	01500	PHARMACY	0	27,090	38,571	65,661	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	43,829	62,405	106,234	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	472,691	673,030	1,145,721	30.00
31.00	03100	INTENSIVE CARE UNIT	0	156,456	222,766	379,222	31.00
43.00	04300	NURSERY	0	2,083	2,966	5,049	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	262,323	373,503	635,826	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,022	7,150	12,172	52.00
53.00	05300	ANESTHESIOLOGY	0	7,603	10,825	18,428	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	93,153	132,634	225,787	54.00
54.01	05401	ULTRASOUND	0	26,655	37,953	64,608	54.01
56.00	05600	RADIOISOTOPE	0	8,830	12,572	21,402	56.00
57.00	05700	CT SCAN	0	15,359	21,869	37,228	57.00
58.00	05800	MRI	0	16,318	23,234	39,552	58.00
60.00	06000	LABORATORY	0	60,543	86,203	146,746	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	3,220	4,585	7,805	62.00
65.00	06500	RESPIRATORY THERAPY	0	13,864	19,740	33,604	65.00
66.00	06600	PHYSICAL THERAPY	0	83,633	119,079	202,712	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,108	3,002	5,110	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,188	1,692	2,880	68.00
69.00	06900	ELECTROCARDIOLOGY	0	53,541	76,233	129,774	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	4,268	6,077	10,345	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	30,105	42,865	72,970	76.01
76.03	03951	WOUND CARE	0	35,958	51,198	87,156	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	121,878	173,534	295,412	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,747,541	3,912,022	6,659,563	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,638	12,299	20,937	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	168,672	240,160	408,832	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	0	3,182	4,530	7,712	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	0	0	194.01
194.02	07952	UNUSED SPACE	0	79,493	113,184	192,677	194.02
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	3,007,526	4,282,195	7,289,721	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0184

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	743,758					5.00
7.00	00700	OPERATION OF PLANT	63,033	1,648,004				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,669	5,136	24,167			8.00
9.00	00900	HOUSEKEEPING	17,925	13,927	0	73,510		9.00
10.00	01000	DIETARY	19,129	37,950	0	1,783	172,375	10.00
11.00	01100	CAFETERIA	2,920	42,889	0	2,015	0	11.00
13.00	01300	NURSING ADMINISTRATION	28,246	59,125	0	2,778	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,276	24,137	0	1,134	0	14.00
15.00	01500	PHARMACY	25,186	21,952	0	1,031	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,074	35,516	0	1,669	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	66,698	383,035	9,473	18,000	130,876	30.00
31.00	03100	INTENSIVE CARE UNIT	35,916	126,781	2,248	5,957	19,557	31.00
43.00	04300	NURSERY	1,883	1,688	0	79	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	99,026	212,569	2,803	9,988	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,033	4,069	0	191	0	52.00
53.00	05300	ANESTHESIOLOGY	1,951	6,161	0	289	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,934	75,485	2,103	3,547	0	54.00
54.01	05401	ULTRASOUND	5,178	21,600	0	1,015	0	54.01
56.00	05600	RADIOISOTOPE	8,792	7,155	0	336	0	56.00
57.00	05700	CT SCAN	7,619	12,446	0	585	0	57.00
58.00	05800	MRI	2,593	13,223	0	621	0	58.00
60.00	06000	LABORATORY	41,402	49,060	0	2,305	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	5,224	2,609	0	123	0	62.00
65.00	06500	RESPIRATORY THERAPY	12,092	11,235	0	528	0	65.00
66.00	06600	PHYSICAL THERAPY	13,834	67,771	943	3,184	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,519	1,709	0	80	0	67.00
68.00	06800	SPEECH PATHOLOGY	697	963	0	45	0	68.00
69.00	06900	ELECTROCARDIOLOGY	35,336	43,386	1,305	2,038	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	42,051	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	36,505	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,672	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	5,130	3,458	0	162	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	4,522	24,395	338	1,146	0	76.01
76.03	03951	WOUND CARE	3,187	29,138	145	1,369	0	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	43,944	98,762	4,809	4,640	7,674	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	727,196	1,437,330	24,167	66,638	158,107	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	309	7,000	0	329	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,084	136,680	0	6,422	14,268	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	822	2,578	0	121	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	6,499	0	0	0	0	194.01
194.02	07952	UNUSED SPACE	2,848	64,416	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)	743,758	1,648,004	24,167	73,510	172,375	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0184

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part II
Date/Time Prepared:
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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	176,110					11.00
13.00	01300	NURSING ADMINISTRATION	10,160	279,525				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,378	0	112,554			14.00
15.00	01500	PHARMACY	9,297	0	692	126,053		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,004	0	135	0	157,944	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	27,454	56,257	2,237	0	9,520	30.00
31.00	03100	INTENSIVE CARE UNIT	12,556	32,819	1,897	0	1,557	31.00
43.00	04300	NURSERY	518	1,994	1	0	53	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	27,505	60,288	26,361	0	26,113	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	984	3,221	3	0	67	52.00
53.00	05300	ANESTHESIOLOGY	0	0	1,069	0	4,741	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,233	27,444	309	0	3,658	54.00
54.01	05401	ULTRASOUND	1,149	2,829	33	0	1,328	54.01
56.00	05600	RADIOISOTOPE	1,457	5,193	68	0	4,105	56.00
57.00	05700	CT SCAN	4,153	7,723	415	0	10,340	57.00
58.00	05800	MRI	773	2,460	7	0	1,805	58.00
60.00	06000	LABORATORY	17,422	0	9,938	0	28,192	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	691	0	0	0	569	62.00
65.00	06500	RESPIRATORY THERAPY	6,458	12,984	835	0	4,069	65.00
66.00	06600	PHYSICAL THERAPY	5,354	0	158	0	3,268	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,322	0	0	0	1,038	67.00
68.00	06800	SPEECH PATHOLOGY	864	0	0	0	197	68.00
69.00	06900	ELECTROCARDIOLOGY	11,422	25,047	1,729	0	15,921	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	30,689	0	3,700	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	31,309	0	10,512	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	126,053	10,132	73.00
74.00	07400	RENAL DIALYSIS	0	0	54	0	671	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	75	0	423	76.01
76.03	03951	WOUND CARE	909	2,128	128	0	71	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	14,628	39,138	4,407	0	15,894	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	174,691	279,525	112,549	126,053	157,944	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	691	0	5	0	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	728	0	0	0	0	194.01
194.02	07952	UNUSED SPACE	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)	176,110	279,525	112,554	126,053	157,944	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0184

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part II
Date/Time Prepared:
9/30/2020 10:19 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	1,853,796	0	1,853,796	30.00
31.00	03100	INTENSIVE CARE UNIT	621,150	0	621,150	31.00
43.00	04300	NURSERY	11,425	0	11,425	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,105,329	0	1,105,329	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	23,999	0	23,999	52.00
53.00	05300	ANESTHESIOLOGY	32,639	0	32,639	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	388,707	0	388,707	54.00
54.01	05401	ULTRASOUND	97,968	0	97,968	54.01
56.00	05600	RADIOISOTOPE	48,926	0	48,926	56.00
57.00	05700	CT SCAN	81,130	0	81,130	57.00
58.00	05800	MRI	61,232	0	61,232	58.00
60.00	06000	LABORATORY	297,007	0	297,007	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	17,130	0	17,130	62.00
65.00	06500	RESPIRATORY THERAPY	82,849	0	82,849	65.00
66.00	06600	PHYSICAL THERAPY	298,279	0	298,279	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,113	0	13,113	67.00
68.00	06800	SPEECH PATHOLOGY	5,710	0	5,710	68.00
69.00	06900	ELECTROCARDIOLOGY	267,973	0	267,973	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	76,440	0	76,440	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	78,326	0	78,326	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	165,857	0	165,857	73.00
74.00	07400	RENAL DIALYSIS	19,820	0	19,820	74.00
76.00	03020	ACUPUNCTURE	0	0	0	76.00
76.01	03610	SLEEP LAB	103,869	0	103,869	76.01
76.03	03951	WOUND CARE	124,402	0	124,402	76.03
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	532,456	0	532,456	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,409,532	0	6,409,532	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	28,575	0	28,575	190.00
191.00	19100	RESEARCH	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	572,286	0	572,286	192.00
193.00	19300	NONPAID WORKERS	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	11,997	0	11,997	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	194.00
194.01	07953	MARKETING	7,390	0	7,390	194.01
194.02	07952	UNUSED SPACE	259,941	0	259,941	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)	7,289,721	0	7,289,721	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0184

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

Worksheet B-1

Date/Time Prepared:
9/30/2020 10:19 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	235,364				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		235,364			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,208	1,208	19,999,667		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	23,845	23,845	2,797,407	-12,996,101	5.00
7.00	00700	OPERATION OF PLANT	51,154	51,154	332,002	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	496	496	0	0	8.00
9.00	00900	HOUSEKEEPING	1,345	1,345	0	0	9.00
10.00	01000	DIETARY	3,665	3,665	0	0	10.00
11.00	01100	CAFETERIA	4,142	4,142	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	5,710	5,710	1,264,377	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,331	2,331	231,348	0	14.00
15.00	01500	PHARMACY	2,120	2,120	1,194,021	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,430	3,430	166,601	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	36,992	36,992	2,418,510	0	30.00
31.00	03100	INTENSIVE CARE UNIT	12,244	12,244	1,410,882	0	31.00
43.00	04300	NURSERY	163	163	85,731	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	20,529	20,529	2,592,049	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	393	393	138,490	0	52.00
53.00	05300	ANESTHESIOLOGY	595	595	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,290	7,290	1,179,812	0	54.00
54.01	05401	ULTRASOUND	2,086	2,086	121,604	0	54.01
56.00	05600	RADIOISOTOPE	691	691	223,256	0	56.00
57.00	05700	CT SCAN	1,202	1,202	332,015	0	57.00
58.00	05800	MRI	1,277	1,277	105,759	0	58.00
60.00	06000	LABORATORY	4,738	4,738	1,037,762	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	252	252	58,429	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,085	1,085	558,194	0	65.00
66.00	06600	PHYSICAL THERAPY	6,545	6,545	564,065	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	165	165	179,215	0	67.00
68.00	06800	SPEECH PATHOLOGY	93	93	34,034	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,190	4,190	1,076,782	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	334	334	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	2,356	2,356	0	0	76.01
76.03	03951	WOUND CARE	2,814	2,814	91,472	0	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	9,538	9,538	1,682,574	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	215,018	215,018	19,876,391	-12,996,101	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	676	676	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,200	13,200	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	249	249	36,261	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	87,015	0	194.01
194.02	07952	UNUSED SPACE	6,221	6,221	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)	3,007,526	4,282,195	3,861,093	12,996,101	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.778190	18.193925	0.193058	0.258253	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			37,414	743,758	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001871	0.014780	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0184

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

Worksheet B-1

Date/Time Prepared:
9/30/2020 10:19 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
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: 14-0184

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

Worksheet B-1

Date/Time Prepared:
9/30/2020 10:19 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	159,157				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	496	242,663			8.00
9.00	00900	HOUSEKEEPING	1,345	0	151,095		9.00
10.00	01000	DIETARY	3,665	0	3,665	27,315	10.00
11.00	01100	CAFETERIA	4,142	0	4,142	0	11.00
13.00	01300	NURSING ADMINISTRATION	5,710	0	5,710	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,331	0	2,331	0	14.00
15.00	01500	PHARMACY	2,120	0	2,120	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,430	0	3,430	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	36,992	95,124	36,992	20,739	30.00
31.00	03100	INTENSIVE CARE UNIT	12,244	22,568	12,244	3,099	31.00
43.00	04300	NURSERY	163	0	163	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	20,529	28,149	20,529	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	393	0	393	0	52.00
53.00	05300	ANESTHESIOLOGY	595	0	595	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,290	21,112	7,290	0	54.00
54.01	05401	ULTRASOUND	2,086	0	2,086	0	54.01
56.00	05600	RADIOISOTOPE	691	0	691	0	56.00
57.00	05700	CT SCAN	1,202	0	1,202	0	57.00
58.00	05800	MRI	1,277	0	1,277	0	58.00
60.00	06000	LABORATORY	4,738	0	4,738	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	252	0	252	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,085	0	1,085	0	65.00
66.00	06600	PHYSICAL THERAPY	6,545	9,464	6,545	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	165	0	165	0	67.00
68.00	06800	SPEECH PATHOLOGY	93	0	93	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,190	13,103	4,190	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	334	0	334	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	2,356	3,397	2,356	0	76.01
76.03	03951	WOUND CARE	2,814	1,456	2,814	0	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	9,538	48,290	9,538	1,216	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	138,811	242,663	136,970	25,054	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	676	0	676	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,200	0	13,200	2,261	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	249	0	249	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	0	0	194.01
194.02	07952	UNUSED SPACE	6,221	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)	5,366,111	329,055	1,571,382	1,790,151	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	33.715834	1.356016	10.399960	65.537287	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,648,004	24,167	73,510	172,375	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	10.354581	0.099591	0.486515	6.310635	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: 14-0184

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

Worksheet B-1

Date/Time Prepared:
9/30/2020 10:19 am

Cost Center Description			NURSING ADMINISTRATION (NURSING WA GES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	
			13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	12,017,128				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	9,479,714			14.00
15.00	01500	PHARMACY	0	58,246	2,007,558		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,371	0	551,648,147	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,418,510	188,447	0	33,286,785	30.00
31.00	03100	INTENSIVE CARE UNIT	1,410,882	159,759	0	5,442,986	31.00
43.00	04300	NURSERY	85,730	78	0	184,025	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,592,049	2,220,229	0	91,303,013	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	138,489	276	0	235,687	52.00
53.00	05300	ANESTHESIOLOGY	0	90,062	0	16,576,998	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,179,812	26,035	0	12,788,740	54.00
54.01	05401	ULTRASOUND	121,604	2,798	0	4,643,336	54.01
56.00	05600	RADIOISOTOPE	223,256	5,702	0	14,352,474	56.00
57.00	05700	CT SCAN	332,015	34,936	0	36,153,643	57.00
58.00	05800	MRI	105,759	577	0	6,312,862	58.00
60.00	06000	LABORATORY	0	837,051	0	97,963,831	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,990,942	62.00
65.00	06500	RESPIRATORY THERAPY	558,194	70,348	0	14,228,808	65.00
66.00	06600	PHYSICAL THERAPY	0	13,325	0	11,427,557	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,630,756	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	689,504	68.00
69.00	06900	ELECTROCARDIOLOGY	1,076,782	145,610	0	55,668,123	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,584,771	0	12,936,628	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,636,926	0	36,756,364	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,007,558	35,426,901	73.00
74.00	07400	RENAL DIALYSIS	0	4,570	0	2,347,683	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	6,304	0	1,480,755	76.01
76.03	03951	WOUND CARE	91,472	10,741	0	247,212	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	1,682,574	371,152	0	55,572,534	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,017,128	9,479,314	2,007,558	551,648,147	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	0	400	0	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	0	0	194.01
194.02	07952	UNUSED SPACE	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)	2,681,413	988,375	2,266,511	1,102,590	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.223133	0.104262	1.128989	0.001999	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	279,525	112,554	126,053	157,944	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.023261	0.011873	0.062789	0.000286	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0184

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

Worksheet B-1

Date/Time Prepared:
9/30/2020 10:19 am

Cost Center Description		NURSING ADMINISTRATION (NURSING WA GES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)		
		13.00	14.00	15.00	16.00		
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0184

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part I
Date/Time Prepared:
9/30/2020 10:19 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,491,315		9,491,315	0	9,491,315	30.00
31.00	03100	INTENSIVE CARE UNIT	4,204,536		4,204,536	0	4,204,536	31.00
43.00	04300	NURSERY	188,293		188,293	0	188,293	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,435,334		10,435,334	0	10,435,334	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	309,363		309,363	0	309,363	52.00
53.00	05300	ANESTHESIOLOGY	234,857		234,857	0	234,857	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,730,856		3,730,856	0	3,730,856	54.00
54.01	05401	ULTRASOUND	572,395		572,395	0	572,395	54.01
56.00	05600	RADIOISOTOPE	861,635		861,635	0	861,635	56.00
57.00	05700	CT SCAN	861,828		861,828	0	861,828	57.00
58.00	05800	MRI	315,227		315,227	0	315,227	58.00
60.00	06000	LABORATORY	4,059,300		4,059,300	0	4,059,300	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	461,532		461,532	0	461,532	62.00
65.00	06500	RESPIRATORY THERAPY	1,253,473	0	1,253,473	0	1,253,473	65.00
66.00	06600	PHYSICAL THERAPY	1,516,640	0	1,516,640	0	1,516,640	66.00
67.00	06700	OCCUPATIONAL THERAPY	317,351	0	317,351	0	317,351	67.00
68.00	06800	SPEECH PATHOLOGY	66,891	0	66,891	0	66,891	68.00
69.00	06900	ELECTROCARDIOLOGY	3,605,546		3,605,546	0	3,605,546	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,875,202		3,875,202	0	3,875,202	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,456,140		3,456,140	0	3,456,140	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,863,345		4,863,345	0	4,863,345	73.00
74.00	07400	RENAL DIALYSIS	456,670		456,670	0	456,670	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	497,097		497,097	0	497,097	76.01
76.03	03951	WOUND CARE	421,704		421,704	0	421,704	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	4,868,062		4,868,062	0	4,868,062	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,404,104		2,404,104		2,404,104	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
200.00		Subtotal (see instructions)	63,328,696	0	63,328,696	0	63,328,696	200.00
201.00		Less Observation Beds	2,404,104		2,404,104		2,404,104	201.00
202.00		Total (see instructions)	60,924,592	0	60,924,592	0	60,924,592	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0184

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part I
Date/Time Prepared:
9/30/2020 10:19 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	25,514,175		25,514,175			30.00
31.00	03100	INTENSIVE CARE UNIT	5,442,986		5,442,986			31.00
43.00	04300	NURSERY	184,025		184,025			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	25,541,560	65,761,453	91,303,013	0.114293	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	229,716	5,971	235,687	1.312601	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	5,118,237	11,458,761	16,576,998	0.014168	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,487,428	10,301,312	12,788,740	0.291730	0.000000	54.00
54.01	05401	ULTRASOUND	1,146,670	3,496,666	4,643,336	0.123272	0.000000	54.01
56.00	05600	RADIOISOTOPE	3,963,877	10,388,597	14,352,474	0.060034	0.000000	56.00
57.00	05700	CT SCAN	8,406,484	27,747,159	36,153,643	0.023838	0.000000	57.00
58.00	05800	MRI	767,774	5,545,088	6,312,862	0.049934	0.000000	58.00
60.00	06000	LABORATORY	31,053,297	66,910,534	97,963,831	0.041437	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	660,201	1,330,741	1,990,942	0.231816	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	11,456,715	2,772,093	14,228,808	0.088094	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,650,212	5,777,345	11,427,557	0.132718	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,587,104	1,043,652	3,630,756	0.087406	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	441,363	248,141	689,504	0.097013	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	32,664,892	23,003,231	55,668,123	0.064769	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,979,530	5,957,098	12,936,628	0.299553	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,425,832	16,330,532	36,756,364	0.094028	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,146,268	15,280,633	35,426,901	0.137278	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,078,994	268,689	2,347,683	0.194519	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	9,953	1,470,802	1,480,755	0.335705	0.000000	76.01
76.03	03951	WOUND CARE	22,747	224,465	247,212	1.705840	0.000000	76.03
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	12,099,629	43,472,905	55,572,534	0.087598	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,605,131	5,167,479	7,772,610	0.309305	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
200.00		Subtotal (see instructions)	227,684,800	323,963,347	551,648,147			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	227,684,800	323,963,347	551,648,147			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0184

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part I
Date/Time Prepared:
9/30/2020 10:19 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	0.114293			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.312601			52.00
53.00	05300 ANESTHESIOLOGY	0.014168			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.291730			54.00
54.01	05401 ULTRASOUND	0.123272			54.01
56.00	05600 RADIOISOTOPE	0.060034			56.00
57.00	05700 CT SCAN	0.023838			57.00
58.00	05800 MRI	0.049934			58.00
60.00	06000 LABORATORY	0.041437			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.231816			62.00
65.00	06500 RESPIRATORY THERAPY	0.088094			65.00
66.00	06600 PHYSICAL THERAPY	0.132718			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.087406			67.00
68.00	06800 SPEECH PATHOLOGY	0.097013			68.00
69.00	06900 ELECTROCARDIOLOGY	0.064769			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.299553			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.094028			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.137278			73.00
74.00	07400 RENAL DIALYSIS	0.194519			74.00
76.00	03020 ACUPUNCTURE	0.000000			76.00
76.01	03610 SLEEP LAB	0.335705			76.01
76.03	03951 WOUND CARE	1.705840			76.03
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.087598			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.309305			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000			96.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0184

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part I
Date/Time Prepared:
9/30/2020 10:19 am

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,491,315		9,491,315	0	9,491,315	30.00
31.00	03100	INTENSIVE CARE UNIT	4,204,536		4,204,536	0	4,204,536	31.00
43.00	04300	NURSERY	188,293		188,293	0	188,293	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,435,334		10,435,334	0	10,435,334	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	309,363		309,363	0	309,363	52.00
53.00	05300	ANESTHESIOLOGY	234,857		234,857	0	234,857	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,730,856		3,730,856	0	3,730,856	54.00
54.01	05401	ULTRASOUND	572,395		572,395	0	572,395	54.01
56.00	05600	RADIOISOTOPE	861,635		861,635	0	861,635	56.00
57.00	05700	CT SCAN	861,828		861,828	0	861,828	57.00
58.00	05800	MRI	315,227		315,227	0	315,227	58.00
60.00	06000	LABORATORY	4,059,300		4,059,300	0	4,059,300	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	461,532		461,532	0	461,532	62.00
65.00	06500	RESPIRATORY THERAPY	1,253,473	0	1,253,473	0	1,253,473	65.00
66.00	06600	PHYSICAL THERAPY	1,516,640	0	1,516,640	0	1,516,640	66.00
67.00	06700	OCCUPATIONAL THERAPY	317,351	0	317,351	0	317,351	67.00
68.00	06800	SPEECH PATHOLOGY	66,891	0	66,891	0	66,891	68.00
69.00	06900	ELECTROCARDIOLOGY	3,605,546		3,605,546	0	3,605,546	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,875,202		3,875,202	0	3,875,202	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,456,140		3,456,140	0	3,456,140	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,863,345		4,863,345	0	4,863,345	73.00
74.00	07400	RENAL DIALYSIS	456,670		456,670	0	456,670	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	497,097		497,097	0	497,097	76.01
76.03	03951	WOUND CARE	421,704		421,704	0	421,704	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	4,868,062		4,868,062	0	4,868,062	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,404,104		2,404,104		2,404,104	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
200.00		Subtotal (see instructions)	63,328,696	0	63,328,696	0	63,328,696	200.00
201.00		Less Observation Beds	2,404,104		2,404,104		2,404,104	201.00
202.00		Total (see instructions)	60,924,592	0	60,924,592	0	60,924,592	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0184

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part I
Date/Time Prepared:
9/30/2020 10:19 am

			Title XIX		Hospital	Cost		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	25,514,175		25,514,175			30.00
31.00	03100	INTENSIVE CARE UNIT	5,442,986		5,442,986			31.00
43.00	04300	NURSERY	184,025		184,025			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	25,541,560	65,761,453	91,303,013	0.114293	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	229,716	5,971	235,687	1.312601	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	5,118,237	11,458,761	16,576,998	0.014168	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,487,428	10,301,312	12,788,740	0.291730	0.000000	54.00
54.01	05401	ULTRASOUND	1,146,670	3,496,666	4,643,336	0.123272	0.000000	54.01
56.00	05600	RADIOISOTOPE	3,963,877	10,388,597	14,352,474	0.060034	0.000000	56.00
57.00	05700	CT SCAN	8,406,484	27,747,159	36,153,643	0.023838	0.000000	57.00
58.00	05800	MRI	767,774	5,545,088	6,312,862	0.049934	0.000000	58.00
60.00	06000	LABORATORY	31,053,297	66,910,534	97,963,831	0.041437	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	660,201	1,330,741	1,990,942	0.231816	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	11,456,715	2,772,093	14,228,808	0.088094	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,650,212	5,777,345	11,427,557	0.132718	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,587,104	1,043,652	3,630,756	0.087406	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	441,363	248,141	689,504	0.097013	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	32,664,892	23,003,231	55,668,123	0.064769	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,979,530	5,957,098	12,936,628	0.299553	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,425,832	16,330,532	36,756,364	0.094028	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,146,268	15,280,633	35,426,901	0.137278	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,078,994	268,689	2,347,683	0.194519	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	9,953	1,470,802	1,480,755	0.335705	0.000000	76.01
76.03	03951	WOUND CARE	22,747	224,465	247,212	1.705840	0.000000	76.03
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	12,099,629	43,472,905	55,572,534	0.087598	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,605,131	5,167,479	7,772,610	0.309305	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
200.00		Subtotal (see instructions)	227,684,800	323,963,347	551,648,147			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	227,684,800	323,963,347	551,648,147			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0184

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part I
Date/Time Prepared:
9/30/2020 10:19 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	05401	ULTRASOUND	0.000000			54.01
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000			62.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
76.00	03020	ACUPUNCTURE	0.000000			76.00
76.01	03610	SLEEP LAB	0.000000			76.01
76.03	03951	WOUND CARE	0.000000			76.03
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000			96.00
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: 14-0184

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part I
Date/Time Prepared:
9/30/2020 10:19 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	1,853,796	0	1,853,796	8,500	218.09	30.00
31.00	INTENSIVE CARE UNIT	621,150		621,150	973	638.39	31.00
43.00	NURSERY	11,425		11,425	84	136.01	43.00
200.00	Total (lines 30 through 199)	2,486,371		2,486,371	9,557		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,683	803,225				30.00
31.00	INTENSIVE CARE UNIT	460	293,659				31.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	4,143	1,096,884				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0184

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part II
Date/Time Prepared:
9/30/2020 10:19 am

Cost Center Description			Title XVIII		Hospital	PPS		
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,105,329	91,303,013	0.012106	11,720,152	141,884	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	23,999	235,687	0.101826	0	0	52.00
53.00	05300	ANESTHESIOLOGY	32,639	16,576,998	0.001969	2,561,505	5,044	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	388,707	12,788,740	0.030394	1,322,400	40,193	54.00
54.01	05401	ULTRASOUND	97,968	4,643,336	0.021099	571,044	12,048	54.01
56.00	05600	RADIOISOTOPE	48,926	14,352,474	0.003409	1,688,643	5,757	56.00
57.00	05700	CT SCAN	81,130	36,153,643	0.002244	3,523,426	7,907	57.00
58.00	05800	MRI	61,232	6,312,862	0.009700	460,033	4,462	58.00
60.00	06000	LABORATORY	297,007	97,963,831	0.003032	14,039,842	42,569	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	17,130	1,990,942	0.008604	435,849	3,750	62.00
65.00	06500	RESPIRATORY THERAPY	82,849	14,228,808	0.005823	4,545,207	26,467	65.00
66.00	06600	PHYSICAL THERAPY	298,279	11,427,557	0.026102	2,931,813	76,526	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,113	3,630,756	0.003612	1,214,700	4,387	67.00
68.00	06800	SPEECH PATHOLOGY	5,710	689,504	0.008281	164,151	1,359	68.00
69.00	06900	ELECTROCARDIOLOGY	267,973	55,668,123	0.004814	14,054,889	67,660	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	76,440	12,936,628	0.005909	3,241,323	19,153	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	78,326	36,756,364	0.002131	10,637,579	22,669	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	165,857	35,426,901	0.004682	7,962,983	37,283	73.00
74.00	07400	RENAL DIALYSIS	19,820	2,347,683	0.008442	1,054,443	8,902	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	103,869	1,480,755	0.070146	9,907	695	76.01
76.03	03951	WOUND CARE	124,402	247,212	0.503220	7,101	3,573	76.03
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	532,456	55,572,534	0.009581	5,581,853	53,480	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	469,558	7,772,610	0.060412	1,240,098	74,917	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00		Total (lines 50 through 199)	4,392,719	520,506,961		88,968,941	660,685	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0184		Period: From 05/01/2019 To 04/30/2020		Worksheet D Part III Date/Time Prepared: 9/30/2020 10:19 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	8,500	0.00	3,683		30.00	
31.00	03100	INTENSIVE CARE UNIT			0	973	0.00	460		31.00	
43.00	04300	NURSERY			0	84	0.00	0		43.00	
200.00		Total (lines 30 through 199)			0	9,557		4,143		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: 14-0184		Period: From 05/01/2019 To 04/30/2020		Worksheet D Part IV Date/Time Prepared: 9/30/2020 10:19 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 14-0184

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part IV
Date/Time Prepared:
9/30/2020 10:19 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	91,303,013	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	235,687	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	16,576,998	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,788,740	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	4,643,336	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	14,352,474	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	36,153,643	0.000000	57.00
58.00	05800	MRI	0	0	0	6,312,862	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	97,963,831	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,990,942	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,228,808	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	11,427,557	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,630,756	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	689,504	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	55,668,123	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	12,936,628	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	36,756,364	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	35,426,901	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,347,683	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	1,480,755	0.000000	76.01
76.03	03951	WOUND CARE	0	0	0	247,212	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	55,572,534	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	7,772,610	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0.000000	96.00
200.00		Total (lines 50 through 199)	0	0	0	520,506,961		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0184

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part IV
Date/Time Prepared:
9/30/2020 10:19 am

Cost Center Description		Title XVIII			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	11,720,152	0	21,755,696	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	2,561,505	0	3,834,301	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,322,400	0	3,440,371	0	54.00
54.01	05401	ULTRASOUND	0.000000	571,044	0	1,237,010	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	1,688,643	0	3,039,602	0	56.00
57.00	05700	CT SCAN	0.000000	3,523,426	0	8,531,189	0	57.00
58.00	05800	MRI	0.000000	460,033	0	2,202,175	0	58.00
60.00	06000	LABORATORY	0.000000	14,039,842	0	8,671,756	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	435,849	0	1,103,077	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	4,545,207	0	1,161,384	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	2,931,813	0	201,038	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,214,700	0	89,401	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	164,151	0	5,150	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	14,054,889	0	9,048,214	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	3,241,323	0	2,018,707	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	10,637,579	0	6,832,004	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	7,962,983	0	7,941,495	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	1,054,443	0	195,166	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	9,907	0	491,660	0	76.01
76.03	03951	WOUND CARE	0.000000	7,101	0	115,029	0	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.000000	5,581,853	0	10,160,113	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,240,098	0	1,880,388	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		88,968,941	0	93,954,926	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0184

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part V
Date/Time Prepared:
9/30/2020 10:19 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	0.114293	21,755,696	51,808	0	2,486,524	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.312601	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.014168	3,834,301	0	0	54,324	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.291730	3,440,371	0	0	1,003,659	54.00
54.01	05401	ULTRASOUND	0.123272	1,237,010	0	0	152,489	54.01
56.00	05600	RADIOISOTOPE	0.060034	3,039,602	0	0	182,479	56.00
57.00	05700	CT SCAN	0.023838	8,531,189	0	0	203,366	57.00
58.00	05800	MRI	0.049934	2,202,175	0	0	109,963	58.00
60.00	06000	LABORATORY	0.041437	8,671,756	10,346	0	359,332	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.231816	1,103,077	0	0	255,711	62.00
65.00	06500	RESPIRATORY THERAPY	0.088094	1,161,384	0	0	102,311	65.00
66.00	06600	PHYSICAL THERAPY	0.132718	201,038	0	0	26,681	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.087406	89,401	0	0	7,814	67.00
68.00	06800	SPEECH PATHOLOGY	0.097013	5,150	0	0	500	68.00
69.00	06900	ELECTROCARDIOLOGY	0.064769	9,048,214	0	0	586,044	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.299553	2,018,707	0	0	604,710	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.094028	6,832,004	0	0	642,400	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.137278	7,941,495	29,925	0	1,090,193	73.00
74.00	07400	RENAL DIALYSIS	0.194519	195,166	3,004	0	37,963	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.335705	491,660	0	0	165,053	76.01
76.03	03951	WOUND CARE	1.705840	115,029	0	0	196,221	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.087598	10,160,113	0	0	890,006	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.309305	1,880,388	0	0	581,613	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.000000	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Subtotal (see instructions)		93,954,926	95,083	0	9,739,356	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		93,954,926	95,083	0	9,739,356	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0184

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part V
Date/Time Prepared:
9/30/2020 10:19 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	5,921	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	429	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,108	0		73.00
74.00	07400	RENAL DIALYSIS	584	0		74.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.03	03951	WOUND CARE	0	0		76.03
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	11,042	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	11,042	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0184	Period: From 05/01/2019 To 04/30/2020	Worksheet D-1 Date/Time Prepared: 9/30/2020 10:19 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)		8,500	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		8,500	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)		6,347	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)		3,683	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)		9,491,315	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)		9,491,315	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)		9,491,315	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)		1,116.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,112,548	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)		4,112,548	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0184

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

Worksheet D-1

Date/Time Prepared:
9/30/2020 10:19 am

			Title XVIII		Hospital	PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00			
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	4,204,536	973	4,321.21	460	1,987,757	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					8,702,467	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					14,802,772	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,096,884	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					660,685	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,757,569	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					13,045,203	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					2,153	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,116.63	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,404,104	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0184

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

Worksheet D-1

Date/Time Prepared:
9/30/2020 10:19 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	1,853,796	9,491,315	0.195315	2,404,104	469,558	90.00
91.00 Nursing School cost	0	9,491,315	0.000000	2,404,104	0	91.00
92.00 Allied health cost	0	9,491,315	0.000000	2,404,104	0	92.00
93.00 All other Medical Education	0	9,491,315	0.000000	2,404,104	0	93.00

Health Financial Systems		HEARTLAND REGIONAL MEDICAL CENTER		In Lieu of Form CMS-2552-10	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0184	Period: From 05/01/2019 To 04/30/2020	Worksheet D-3 Date/Time Prepared: 9/30/2020 10:19 am
			Title XVIII	Hospital	PPS
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		15,350,674	30.00
31.00	03100	INTENSIVE CARE UNIT		2,567,320	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.114293	11,720,152	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.312601	0	52.00
53.00	05300	ANESTHESIOLOGY	0.014168	2,561,505	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.291730	1,322,400	54.00
54.01	05401	ULTRASOUND	0.123272	571,044	54.01
56.00	05600	RADIOISOTOPE	0.060034	1,688,643	56.00
57.00	05700	CT SCAN	0.023838	3,523,426	57.00
58.00	05800	MRI	0.049934	460,033	58.00
60.00	06000	LABORATORY	0.041437	14,039,842	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.231816	435,849	62.00
65.00	06500	RESPIRATORY THERAPY	0.088094	4,545,207	65.00
66.00	06600	PHYSICAL THERAPY	0.132718	2,931,813	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.087406	1,214,700	67.00
68.00	06800	SPEECH PATHOLOGY	0.097013	164,151	68.00
69.00	06900	ELECTROCARDIOLOGY	0.064769	14,054,889	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.299553	3,241,323	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.094028	10,637,579	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.137278	7,962,983	73.00
74.00	07400	RENAL DIALYSIS	0.194519	1,054,443	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	76.00
76.01	03610	SLEEP LAB	0.335705	9,907	76.01
76.03	03951	WOUND CARE	1.705840	7,101	76.03
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.087598	5,581,853	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.309305	1,240,098	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		88,968,941	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		88,968,941	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0184

Period:
From 05/01/2019
To 04/30/2020Worksheet E
Part A
Date/Time Prepared:
9/30/2020 10:19 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)			4,811,329	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			6,301,302	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)			18,940	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			8,394	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)			88.12	4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)			0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)			0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)			0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00	11.00
12.00	Current year allowable FTE (see instructions)			0.00	12.00
13.00	Total allowable FTE count for the prior year.			0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.			0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.00	15.00
16.00	Adjustment for residents in initial years of the program			0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00	17.00
18.00	Adjusted rolling average FTE count			0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	21.00
22.00	IME payment adjustment (see instructions)			0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).			0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)			0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)			0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)			0	28.01
29.00	Total IME payment (sum of lines 22 and 28)			0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			5.32	30.00
31.00	Percentage of Medicaid patient days (see instructions)			17.32	31.00
32.00	Sum of lines 30 and 31			22.64	32.00
33.00	Allowable disproportionate share percentage (see instructions)			7.89	33.00
34.00	Disproportionate share adjustment (see instructions)			219,197	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0184	Period: From 05/01/2019 To 04/30/2020	Worksheet E Part A Date/Time Prepared: 9/30/2020 10:19 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)	667,497	548,861		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	279,800	319,419		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	599,219			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)	11,958,381			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0			48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)		11,958,381		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		885,969		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)		12,844,350		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		12,844,350		61.00
62.00	Deductibles billed to program beneficiaries		1,257,496		62.00
63.00	Coinsurance billed to program beneficiaries		14,069		63.00
64.00	Allowable bad debts (see instructions)		366,745		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		238,384		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		201,988		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		11,811,169		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0		70.50
70.87	Demonstration payment adjustment amount before sequestration		0		70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0		70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)				70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		36,134		70.93
70.94	HRR adjustment amount (see instructions)		-118,260		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0184	Period: From 05/01/2019 To 04/30/2020	Worksheet E Part A Date/Time Prepared: 9/30/2020 10:19 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)		11,729,043	71.00
71.01	Sequestration adjustment (see instructions)		234,581	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		11,668,771	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)		-174,309	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		563,792	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0184	Period: From 05/01/2019 To 04/30/2020	Worksheet E Part B Date/Time Prepared: 9/30/2020 10:19 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		11,042	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		9,739,356	2.00
3.00	OPPS payments		6,779,403	3.00
4.00	Outlier payment (see instructions)		72,925	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)		11,042	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		95,083	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)		95,083	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)		95,083	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		84,041	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)		11,042	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)		6,852,328	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		10,962	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,315,785	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)		5,536,623	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)		5,536,623	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		5,536,623	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)		451,468	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		293,454	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		279,678	36.00
37.00	Subtotal (see instructions)		5,830,077	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		5,830,077	40.00
40.01	Sequestration adjustment (see instructions)		116,602	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		5,648,253	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)		65,222	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: 14-0184

Period:
From 05/01/2019
To 04/30/2020Worksheet E-1
Part I
Date/Time Prepared:
9/30/2020 10:19 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		11,626,671		5,648,253	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	11/13/2019	42,100		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)		42,100		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)		11,668,771		5,648,253	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		65,222	6.01
6.02	SETTLEMENT TO PROGRAM		174,309		0	6.02
7.00	Total Medicare program liability (see instructions)		11,494,462		5,713,475	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: 14-0184

Period:
From 05/01/2019
To 04/30/2020Worksheet E-1
Part II
Date/Time Prepared:
9/30/2020 10:19 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

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

Provider CCN: 14-0184

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

Worksheet G

Date/Time Prepared:
9/30/2020 10:19 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	-668,783	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	19,972,050	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-5,868,200	0	0	0	6.00
7.00	Inventory	3,147,987	0	0	0	7.00
8.00	Prepaid expenses	688,604	0	0	0	8.00
9.00	Other current assets	711,599	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	17,983,257	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,393,860	0	0	0	12.00
13.00	Land improvements	822,554	0	0	0	13.00
14.00	Accumulated depreciation	-456,507	0	0	0	14.00
15.00	Buildings	47,036,787	0	0	0	15.00
16.00	Accumulated depreciation	-15,923,650	0	0	0	16.00
17.00	Leasehold improvements	6,701,353	0	0	0	17.00
18.00	Accumulated depreciation	-3,564,438	0	0	0	18.00
19.00	Fixed equipment	2,614,301	0	0	0	19.00
20.00	Accumulated depreciation	-2,097,425	0	0	0	20.00
21.00	Automobiles and trucks	39,682	0	0	0	21.00
22.00	Accumulated depreciation	-10,637	0	0	0	22.00
23.00	Major movable equipment	19,048,336	0	0	0	23.00
24.00	Accumulated depreciation	-16,324,860	0	0	0	24.00
25.00	Minor equipment depreciable	6,391,185	0	0	0	25.00
26.00	Accumulated depreciation	-5,822,128	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	39,848,413	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	9,983,313	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	9,983,313	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	67,814,983	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	14,225,530	0	0	0	37.00
38.00	Salaries, wages, and fees payable	857,803	0	0	0	38.00
39.00	Payroll taxes payable	173,005	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,349,464	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	-134,953,669	0	0	0	43.00
44.00	Other current liabilities	10,535,769	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-107,812,098	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-107,812,098	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	175,627,081	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)	175,627,081	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	67,814,983	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0184

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

Worksheet G-1

Date/Time Prepared:
9/30/2020 10:19 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		157,592,479		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		18,034,603				2.00
3.00	Total (sum of line 1 and line 2)		175,627,082		0		3.00
4.00	Additions (credit adjustments) (specify)	-1		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)		-1		0		10.00
11.00	Subtotal (line 3 plus line 10)		175,627,081		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)		175,627,081		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: 14-0184

Period:
From 05/01/2019
To 04/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
9/30/2020 10:19 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	25,698,200		25,698,200	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)	25,698,200		25,698,200	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,442,986		5,442,986	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	5,442,986		5,442,986	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	31,141,186		31,141,186	17.00
18.00	Ancillary services	181,838,854	275,322,963	457,161,817	18.00
19.00	Outpatient services	14,704,760	48,640,384	63,345,144	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	ANESTHESIA PROFESSIONAL FEES	401,118	758,481	1,159,599	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	228,085,918	324,721,828	552,807,746	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		76,995,665		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		76,995,665		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0184

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

Worksheet G-3

Date/Time Prepared:
9/30/2020 10:19 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	552,807,746	1.00
2.00	Less contractual allowances and discounts on patients' accounts	457,875,890	2.00
3.00	Net patient revenues (line 1 minus line 2)	94,931,856	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	76,995,665	4.00
5.00	Net income from service to patients (line 3 minus line 4)	17,936,191	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	149,194	24.00
25.00	Total other income (sum of lines 6-24)	149,194	25.00
26.00	Total (line 5 plus line 25)	18,085,385	26.00
27.00	OTHER RECONCILING ITEMS	50,782	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	50,782	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	18,034,603	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0184	Period: From 05/01/2019 To 04/30/2020	Worksheet L Parts I-III Date/Time Prepared: 9/30/2020 10:19 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		880,994	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		4,975	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)		20.04	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)		885,969	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