

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: 14-1334	Period: From 04/01/2019 To 03/31/2020	Worksheet S Parts I-III Date/Time Prepared: 8/18/2020 2:56 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 8/18/2020	Time: 2:56 pm
	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 SAINT JOSEPH MEMORIAL (14-1334) for the cost reporting period beginning 04/01/2019 and ending 03/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	68,119	1,187,755	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	-326,419	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	-258,300	1,187,755	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1334		Period: From 04/01/2019 To 03/31/2020		Worksheet S-2 Part I Date/Time Prepared: 8/18/2020 2:52 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 2 S. HOSPITAL DRIVE			PO Box:				1.00	
2.00	City: MURPHYSBORO			State: IL		Zip Code: 62966		County:	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			SAINT JOSEPH MEMORIAL	141334	16060	1	05/01/2004	N
4.00	Subprovider - IPF							0	0
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF			SAINT JOSEPH HOSPITAL SWING BED	14Z334	16060		11/14/2013	N
8.00	Swing Beds - NF							0	0
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						04/01/2019	03/31/2020	
21.00	Type of Control (see instructions)						2		
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	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)					N	N		
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 days	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1334

Period:
From 04/01/2019
To 03/31/2020Worksheet S-2
Part I
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		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
						Urban/Rural S	Date of Geogr	
						1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
						Beginning:	Ending:	
						1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					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.					N		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
				1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.					N		60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1334

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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

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			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
					1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1334	Period: From 04/01/2019 To 03/31/2020	Worksheet S-2 Part I Date/Time Prepared: 8/18/2020 2:52 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	547,395	0	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H124	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1334		Period: From 04/01/2019 To 03/31/2020		Worksheet S-2 Part I Date/Time Prepared: 8/18/2020 2:52 pm		
1.00		2.00		3.00						
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.										
141.00	Name: SOUTHERN ILLINOIS HEALTHCARE		Contractor's Name: NGS		Contractor's Number: 06101				141.00	
142.00	Street: 1239 E. MAIN ST.		PO Box: 3988						142.00	
143.00	City: CARBONDALE		State: IL		Zip Code: 62902				143.00	
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00	
								1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							N	145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								146.00	
								1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00	
				Part A 1.00	Part B 2.00	Title V 3.00	Title XIX 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 0	County 1.00	State 2.00	Zip Code 3.00	CBSA 4.00	FTE/Campus 5.00			
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00			166.00
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00	
							Beginning 1.00	Ending 2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00	
							1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1334	Period: From 04/01/2019 To 03/31/2020	Worksheet S-2 Part II Date/Time Prepared: 8/18/2020 2:52 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	06/17/2020	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		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		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		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1334

Period:
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		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		Y		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LUANNE	WARREN		41.00
42.00	Enter the employer/company name of the cost report preparer.	SOUTHERN ILLINOIS HEALTHCARE			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	6184575200	LUANNE.WARREN@SIH.NET		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1334

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

Health Financial Systems		SAINT JOSEPH MEMORIAL		Non-CMS HFS Worksheet	
HFS Supplemental Information		Provider CCN: 14-1334	Period: From 04/01/2019 To 03/31/2020	Worksheet S-2 Part IX Date/Time Prepared: 8/18/2020 2:52 pm	
			Title V 1.00	Title XIX 2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE					
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)	Y	Y	1.00	
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.01)	Y	Y	2.00	
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.02)	Y	Y	3.00	
3.01	Do Title V or XIX use W/S D-1 for reimbursement?	N	N	3.01	
			Inpatient 1.00	Outpatient 2.00	
CRITICAL ACCESS HOSPITALS					
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	4.00	
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	5.00	
			Title V 1.00	Title XIX 2.00	
RCE DISALLOWANCE					
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.05)	Y	Y	6.00	
PASS THROUGH COST					
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.06)	Y	Y	7.00	
RHC					
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	8.00	
FQHC					
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	9.00	
			State 1.00		
STATE MEDICAID FORMS					
10.00	Select the state when using state Medicaid forms.				10.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1334

Period:
From 04/01/2019
To 03/31/2020Worksheet S-3
Part I
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Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,150	21,406.88	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	21,406.88	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,150	21,406.88	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

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To 03/31/2020Worksheet S-3
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Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	447	19	853			1.00
2.00	HMO and other (see instructions)	64	165				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	2,164	0	2,888			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	237			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,611	19	3,978			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	2,611	19	3,978	0.00	227.40	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	227.40	27.00
28.00	Observation Bed Days		8	394			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1334

Period:
From 04/01/2019
To 03/31/2020Worksheet S-3
Part I
Date/Time Prepared:
8/18/2020 2:52 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	178	6	338	1.00
2.00 HMO and other (see instructions)			27	59		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	178	6	338	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1334

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

Worksheet S-10

Date/Time Prepared:
8/18/2020 2:52 pm

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.215635	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		8,242,407	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		3,664,339	5.00
6.00	Medicaid charges		51,501,407	6.00
7.00	Medicaid cost (line 1 times line 6)		11,105,506	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		15,410	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)	1,774,184	661,695	2,435,879
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	382,576	661,695	1,044,271
22.00	Payments received from patients for amounts previously written off as charity care	210	0	210
23.00	Cost of charity care (line 21 minus line 22)	382,366	661,695	1,044,061
			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)		5,821,694	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		1,878,457	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		2,889,933	27.01
28.00	Non-Medicare bad debt expense (see instructions)		2,931,761	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,643,666	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		2,687,727	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,687,727	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1334

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

Worksheet A

Date/Time Prepared:
8/18/2020 2:52 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,466,409	1,466,409	159,342	1,625,751	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,642,557	1,642,557	85,799	1,728,356	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	49,471	5,367,607	5,417,078	0	5,417,078	4.00
5.01	00550	DATA PROCESSING	0	0	0	0	0	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	40,919	10,535	51,454	0	51,454	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	596,562	17,264	613,826	0	613,826	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	790,066	2,997,908	3,787,974	-88,347	3,699,627	5.04
6.00	00600	MAINTENANCE & REPAIRS	315,522	590,614	906,136	0	906,136	6.00
7.00	00700	OPERATION OF PLANT	174,452	16,769	191,221	0	191,221	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	262,594	262,594	0	262,594	8.00
9.00	00900	HOUSEKEEPING	303,048	98,515	401,563	-172	401,391	9.00
10.00	01000	DIETARY	333,311	155,788	489,099	-342,594	146,505	10.00
11.00	01100	CAFETERIA	0	0	0	342,219	342,219	11.00
13.00	01300	NURSING ADMINISTRATION	1,141,079	78,217	1,219,296	0	1,219,296	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	34,639	11	34,650	0	34,650	14.00
15.00	01500	PHARMACY	496,002	8,239,859	8,735,861	0	8,735,861	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	26,430	1,117	27,547	0	27,547	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	814,335	814,335	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,716,121	1,149,380	2,865,501	-36,821	2,828,680	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,113,413	4,368,775	6,482,188	-3,206,561	3,275,627	50.00
51.00	05100	RECOVERY ROOM	146,405	4,789	151,194	-817	150,377	51.00
53.00	05300	ANESTHESIOLOGY	0	872,498	872,498	-826,817	45,681	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,067,963	816,650	1,884,613	-50,518	1,834,095	54.00
60.00	06000	LABORATORY	700,462	1,423,753	2,124,215	0	2,124,215	60.00
64.00	06400	INTRAVENOUS THERAPY	800,540	252,627	1,053,167	-25,537	1,027,630	64.00
65.00	06500	RESPIRATORY THERAPY	438,972	103,806	542,778	-43,380	499,398	65.00
65.01	03610	SLEEP LAB	633,562	210,355	843,917	0	843,917	65.01
65.02	03620	GERIATRIC PSYCH	0	409,287	409,287	0	409,287	65.02
66.00	06600	PHYSICAL THERAPY	866,378	425,887	1,292,265	0	1,292,265	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,395,062	1,395,062	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,805,123	1,805,123	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	205,360	205,360	73.00
76.97	07697	CARDIAC REHABILITATION	307,544	22,899	330,443	0	330,443	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	229,284	260,695	489,979	-12,447	477,532	90.00
91.00	09100	EMERGENCY	1,137,905	2,696,220	3,834,125	-16,435	3,817,690	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		524,440	524,440	-156,794	367,646	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,460,050	34,487,825	48,947,875	0	48,947,875	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	27,212	27,212	0	27,212	192.00
192.01	19201	UNUSED SPACE	0	0	0	0	0	192.01
200.00		TOTAL (SUM OF LINES 118 through 199)	14,460,050	34,515,037	48,975,087	0	48,975,087	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1334

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

Worksheet A

Date/Time Prepared:
8/18/2020 2:52 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	63,577	1,689,328	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,327,078	3,055,434	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,768,401	3,648,677	4.00
5.01	00550	DATA PROCESSING	3,303,184	3,303,184	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	-864	50,590	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	760,523	1,374,349	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	496,382	4,196,009	5.04
6.00	00600	MAINTENANCE & REPAIRS	-17,313	888,823	6.00
7.00	00700	OPERATION OF PLANT	0	191,221	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	262,594	8.00
9.00	00900	HOUSEKEEPING	0	401,391	9.00
10.00	01000	DIETARY	0	146,505	10.00
11.00	01100	CAFETERIA	-127,533	214,686	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,219,296	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	34,650	14.00
15.00	01500	PHARMACY	0	8,735,861	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-8,202	19,345	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-814,335	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-683,722	2,144,958	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-1,383	3,274,244	50.00
51.00	05100	RECOVERY ROOM	0	150,377	51.00
53.00	05300	ANESTHESIOLOGY	0	45,681	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-39,755	1,794,340	54.00
60.00	06000	LABORATORY	-195,233	1,928,982	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,027,630	64.00
65.00	06500	RESPIRATORY THERAPY	0	499,398	65.00
65.01	03610	SLEEP LAB	-9,978	833,939	65.01
65.02	03620	GERIATRIC PSYCH	0	409,287	65.02
66.00	06600	PHYSICAL THERAPY	-466	1,291,799	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,395,062	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,805,123	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	205,360	73.00
76.97	07697	CARDIAC REHABILITATION	0	330,443	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	477,532	90.00
91.00	09100	EMERGENCY	-2,371,209	1,446,481	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-367,646	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-455,296	48,492,579	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-7,254	19,958	192.00
192.01	19201	UNUSED SPACE	0	0	192.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-462,550	48,512,537	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 14-1334

Period:
From 04/01/2019
To 03/31/2020Worksheet Non-CMS W
Date/Time Prepared:
8/18/2020 2:52 pm

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

RECLASSIFICATIONS

Provider CCN: 14-1334

Period:
From 04/01/2019
To 03/31/2020Worksheet A-6
Date/Time Prepared:
8/18/2020 2:52 pm

Increases					
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
A - DIETARY RECLASS					
1.00	CAFETERIA	11.00	233,394	109,088	1.00
	TOTALS		233,394	109,088	
B - MEDICAL SUPPLY RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,200,185	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
	TOTALS		0	3,200,185	
C - DRUG RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	127,334	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
	TOTALS		0	127,334	
D - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	101,916	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	54,878	2.00
	TOTALS		0	156,794	
E - IMPLANTABLE DEVICE RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,805,123	1.00
	TOTALS		0	1,805,123	
F - CONTRAST RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	78,026	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	78,026	
G - CRNA RECLASS					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	814,335	1.00
	TOTALS		0	814,335	
H - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	57,426	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	30,921	2.00
	TOTALS		0	88,347	
500.00	Grand Total: Increases		233,394	6,379,232	500.00

RECLASSIFICATIONS

Provider CCN: 14-1334

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

Worksheet A-6

Date/Time Prepared:
8/18/2020 2:52 pm

	Decreases				Wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other		
	6.00	7.00	8.00	9.00	10.00	
	A - DIETARY RECLASS					
1.00	DIETARY	10.00	233,394	109,088	0	1.00
	TOTALS		233,394	109,088		
	B - MEDICAL SUPPLY RECLASS					
1.00	OPERATING ROOM	50.00	0	3,142,792	0	1.00
2.00	ANESTHESIOLOGY	53.00	0	7,538	0	2.00
3.00	RESPIRATORY THERAPY	65.00	0	33,444	0	3.00
4.00	INTRAVENOUS THERAPY	64.00	0	2,237	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	1,732	0	5.00
6.00	CLINIC	90.00	0	5,739	0	6.00
7.00	HOUSEKEEPING	9.00	0	172	0	7.00
8.00	EMERGENCY	91.00	0	6,524	0	8.00
9.00	RECOVERY ROOM	51.00	0	7	0	9.00
	TOTALS		0	3,200,185		
	C - DRUG RECLASS					
1.00	DIETARY	10.00	0	112	0	1.00
2.00	CAFETERIA	11.00	0	263	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	35,089	0	3.00
4.00	OPERATING ROOM	50.00	0	43,826	0	4.00
5.00	RECOVERY ROOM	51.00	0	810	0	5.00
6.00	ANESTHESIOLOGY	53.00	0	4,944	0	6.00
7.00	EMERGENCY	91.00	0	9,911	0	7.00
8.00	INTRAVENOUS THERAPY	64.00	0	23,300	0	8.00
9.00	CLINIC	90.00	0	6,708	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,371	0	10.00
	TOTALS		0	127,334		
	D - INTEREST RECLASS					
1.00	INTEREST EXPENSE	113.00	0	156,794	9	1.00
2.00		0.00	0	0	9	2.00
	TOTALS		0	156,794		
	E - IMPLANTABLE DEVICE RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,805,123	0	1.00
	TOTALS		0	1,805,123		
	F - CONTRAST RECLASS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	48,147	0	1.00
2.00	OPERATING ROOM	50.00	0	19,943	0	2.00
3.00	RESPIRATORY THERAPY	65.00	0	9,936	0	3.00
	TOTALS		0	78,026		
	G - CRNA RECLASS					
1.00	ANESTHESIOLOGY	53.00	0	814,335	0	1.00
	TOTALS		0	814,335		
	H - PROPERTY INSURANCE					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	88,347	9	1.00
2.00		0.00	0	0	9	2.00
	TOTALS		0	88,347		
500.00	Grand Total: Decreases		233,394	6,379,232		500.00

RECLASSIFICATIONS

Provider CCN: 14-1334

Period:
From 04/01/2019
To 03/31/2020Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
8/18/2020 2:52 pm

Increases					Decreases				
Cost Center	Line #	Salary	Other		Cost Center	Line #	Salary	Other	
2.00	3.00	4.00	5.00		6.00	7.00	8.00	9.00	
A - DIETARY RECLASS									
1.00	CAFETERIA	11.00	233,394	109,088	DIETARY	10.00	233,394	109,088	1.00
	TOTALS		233,394	109,088	TOTALS		233,394	109,088	
B - MEDICAL SUPPLY RECLASS									
1.00	MEDICAL SUPPLIES	71.00	0	3,200,185	OPERATING ROOM	50.00	0	3,142,792	1.00
	CHARGED TO PATIENTS								
2.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	7,538	2.00
3.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	33,444	3.00
4.00		0.00	0	0	INTRAVENOUS THERAPY	64.00	0	2,237	4.00
5.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	1,732	5.00
6.00		0.00	0	0	CLINIC	90.00	0	5,739	6.00
7.00		0.00	0	0	HOUSEKEEPING	9.00	0	172	7.00
8.00		0.00	0	0	EMERGENCY	91.00	0	6,524	8.00
9.00		0.00	0	0	RECOVERY ROOM	51.00	0	7	9.00
	TOTALS		0	3,200,185	TOTALS		0	3,200,185	
C - DRUG RECLASS									
1.00	DRUGS CHARGED TO	73.00	0	127,334	DIETARY	10.00	0	112	1.00
	PATIENTS								
2.00		0.00	0	0	CAFETERIA	11.00	0	263	2.00
3.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	35,089	3.00
4.00		0.00	0	0	OPERATING ROOM	50.00	0	43,826	4.00
5.00		0.00	0	0	RECOVERY ROOM	51.00	0	810	5.00
6.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	4,944	6.00
7.00		0.00	0	0	EMERGENCY	91.00	0	9,911	7.00
8.00		0.00	0	0	INTRAVENOUS THERAPY	64.00	0	23,300	8.00
9.00		0.00	0	0	CLINIC	90.00	0	6,708	9.00
10.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	2,371	10.00
	TOTALS		0	127,334	TOTALS		0	127,334	
D - INTEREST RECLASS									
1.00	CAP REL COSTS-BLDG &	1.00	0	101,916	INTEREST EXPENSE	113.00	0	156,794	1.00
	FIXT								
2.00	CAP REL COSTS-MVBLE	2.00	0	54,878		0.00	0	0	2.00
	EQUIP								
	TOTALS		0	156,794	TOTALS		0	156,794	
E - IMPLANTABLE DEVICE RECLASS									
1.00	IMPL. DEV. CHARGED TO	72.00	0	1,805,123	MEDICAL SUPPLIES	71.00	0	1,805,123	1.00
	PATIENTS				CHARGED TO PATIENTS				
	TOTALS		0	1,805,123	TOTALS		0	1,805,123	
F - CONTRAST RECLASS									
1.00	DRUGS CHARGED TO	73.00	0	78,026	RADIOLOGY-DIAGNOSTIC	54.00	0	48,147	1.00
	PATIENTS								
2.00		0.00	0	0	OPERATING ROOM	50.00	0	19,943	2.00
3.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	9,936	3.00
	TOTALS		0	78,026	TOTALS		0	78,026	
G - CRNA RECLASS									
1.00	NONPHYSICIAN	19.00	0	814,335	ANESTHESIOLOGY	53.00	0	814,335	1.00
	ANESTHETISTS								
	TOTALS		0	814,335	TOTALS		0	814,335	
H - PROPERTY INSURANCE									
1.00	CAP REL COSTS-BLDG &	1.00	0	57,426	OTHER ADMINISTRATIVE	5.04	0	88,347	1.00
	FIXT				AND GENERAL				
2.00	CAP REL COSTS-MVBLE	2.00	0	30,921		0.00	0	0	2.00
	EQUIP								
	TOTALS		0	88,347	TOTALS		0	88,347	
500.00	Grand Total:		233,394	6,379,232	Grand Total:		233,394	6,379,232	500.00
	Increases				Decreases				

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1334

Period:
From 04/01/2019
To 03/31/2020Worksheet A-7
Part I
Date/Time Prepared:
8/18/2020 2:52 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	171,136	0	0	0	0	1.00	
2.00	Land Improvements	1,133,915	64,816	0	64,816	0	2.00	
3.00	Buildings and Fixtures	28,781,217	1,120,582	0	1,120,582	8,668	3.00	
4.00	Building Improvements	0	2,333	0	2,333	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	16,690,456	1,972,630	0	1,972,630	897,152	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	46,776,724	3,160,361	0	3,160,361	905,820	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	46,776,724	3,160,361	0	3,160,361	905,820	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	171,136	0				1.00	
2.00	Land Improvements	1,198,731	0				2.00	
3.00	Buildings and Fixtures	29,893,131	0				3.00	
4.00	Building Improvements	2,333	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	17,765,934	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	49,031,265	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	49,031,265	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1334

Period:
From 04/01/2019
To 03/31/2020Worksheet A-7
Part II
Date/Time Prepared:
8/18/2020 2:52 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,466,409	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,642,557	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,108,966	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,466,409				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,642,557				2.00
3.00	Total (sum of lines 1-2)	0	3,108,966				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1334

Period:
From 04/01/2019
To 03/31/2020Worksheet A-7
Part III
Date/Time Prepared:
8/18/2020 2:52 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	31,265,331	0	31,265,331	0.637661	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	17,765,935	0	17,765,935	0.362339	0	2.00
3.00	Total (sum of lines 1-2)	49,031,266	0	49,031,266	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	1,689,328	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,055,434	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,744,762	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,689,328	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	3,055,434	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	4,744,762	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1334

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

Worksheet A-8

Date/Time Prepared:
8/18/2020 2:52 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,239,065			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	9,659,162			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-127,533	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	-8,202	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-814,335	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1334

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

Worksheet A-8

Date/Time Prepared:
8/18/2020 2:52 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.00	PURCHASE DISCOUNTS	B	-864	PURCHASING RECEIVING AND STORES	5.02	0	33.00
33.01	EMPLOYEE OUTPATIENT INSURANCE PAYMEN	B	-3,250,469	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	LOBBYING EXPENSES	A	-14,588	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.02
33.03	UNRESTRICTED INTEREST REVENUE	B	-72,194	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.03
33.04	LEASEHOLD REVENUE	B	-34,932	CAP REL COSTS-BLDG & FIXT	1.00	9	33.04
33.05	XRAY FILM REVENUE	B	-366	RADIOLOGY-DIAGNOSTIC	54.00	0	33.05
33.06	SHAWNEE PARK DEPR.	A	-8,958	CAP REL COSTS-BLDG & FIXT	1.00	9	33.06
33.07	NONALLOWABLE INTEREST EXPENSE	A	-367,646	INTEREST EXPENSE	113.00	0	33.07
33.08	REAL ESTATE TAXES	A	-4,895	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.08
33.09	MEDICAID PROVIDER TAX	A	-2,146,793	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.09
33.10	CABLE TV	A	-1,964	SLEEP LAB	65.01	0	33.10
33.11	CABLE TV	A	-17,313	MAINTENANCE & REPAIRS	6.00	0	33.11
33.12	SHAWNEE PARK PROPERTY INS.	A	-661	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.12
33.13	REAL ESTATE TAXES	A	-8,014	SLEEP LAB	65.01	0	33.13
33.14	SHAWNEE PARK REAL ESTATE TAXES	A	-2,359	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.14
33.15	CABLE TV	A	-466	PHYSICAL THERAPY	66.00	0	33.15
33.16	MISCELLANEOUS INCOME	B	-95	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.16
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-462,550				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-1334

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

Worksheet A-8-1

Date/Time Prepared:
8/18/2020 2:52 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	107,467	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	1,327,078	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	1,482,068	0	3.00
4.00	5.01	DATA PROCESSING	HOME OFFICE	3,303,184	0	4.00
4.01	5.03	CASHIERING/ACCOUNTS RECEIVAB	HOME OFFICE	760,523	0	4.01
4.02	5.04	OTHER ADMINISTRATIVE AND GEN	HOME OFFICE	2,738,523	0	4.02
4.03	54.00	RADIOLOGY-DIAGNOSTIC	RENT	41,775	81,164	4.03
4.04	60.00	LABORATORY	RENT	21,520	41,812	4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			9,782,138	122,976	5.00

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

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

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

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

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

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

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

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

Provider CCN: 14-1334

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

Worksheet A-8-1

Date/Time Prepared:
8/18/2020 2:52 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	107,467	9		1.00
2.00	1,327,078	9		2.00
3.00	1,482,068	0		3.00
4.00	3,303,184	0		4.00
4.01	760,523	0		4.01
4.02	2,738,523	0		4.02
4.03	-39,389	0		4.03
4.04	-20,292	0		4.04
5.00	9,659,162			5.00

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

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

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

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1334

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

Worksheet A-8-2

Date/Time Prepared:
8/18/2020 2:52 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	DR. A	2,371,209	2,371,209	0	0	0	1.00
2.00	60.00	DR. B	174,941	174,941	0	0	0	2.00
3.00	76.97	DR. C	6,250	0	6,250	0	0	3.00
4.00	65.01	DR. D	18,590	0	18,590	0	0	4.00
5.00	30.00	DR. E	683,722	683,722	0	0	0	5.00
6.00	5.04	DR. F	7,810	7,810	0	0	0	6.00
7.00	90.00	DR. G	2,325	0	2,325	0	0	7.00
8.00	50.00	DR. H	13,863	1,383	12,480	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			3,278,710	3,239,065	39,645		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	DR. A	0	0	0	0	0	1.00
2.00	60.00	DR. B	0	0	0	0	0	2.00
3.00	76.97	DR. C	0	0	0	0	0	3.00
4.00	65.01	DR. D	0	0	0	0	0	4.00
5.00	30.00	DR. E	0	0	0	0	0	5.00
6.00	5.04	DR. F	0	0	0	0	0	6.00
7.00	90.00	DR. G	0	0	0	0	0	7.00
8.00	50.00	DR. H	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	DR. A	0	0	0	2,371,209		1.00
2.00	60.00	DR. B	0	0	0	174,941		2.00
3.00	76.97	DR. C	0	0	0	0		3.00
4.00	65.01	DR. D	0	0	0	0		4.00
5.00	30.00	DR. E	0	0	0	683,722		5.00
6.00	5.04	DR. F	0	0	0	7,810		6.00
7.00	90.00	DR. G	0	0	0	0		7.00
8.00	50.00	DR. H	0	0	0	1,383		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	3,239,065		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1334

Period:
From 04/01/2019
To 03/31/2020Worksheet B
Part I
Date/Time Prepared:
8/18/2020 2:52 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	5.01
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,689,328	1,689,328			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,055,434		3,055,434		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,648,677	15,785	28,550	3,693,012	4.00
5.01	00550	DATA PROCESSING	3,303,184	7,527	13,615	0	3,324,326 5.01
5.02	00560	PURCHASING RECEIVING AND STORES	50,590	7,441	13,457	10,486	9,338 5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,374,349	22,339	40,404	152,882	149,408 5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	4,196,009	335,342	606,526	202,471	345,506 5.04
6.00	00600	MAINTENANCE & REPAIRS	888,823	148,376	268,363	80,859	149,408 6.00
7.00	00700	OPERATION OF PLANT	191,221	23,904	43,234	44,707	28,014 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	262,594	11,717	21,192	0	0 8.00
9.00	00900	HOUSEKEEPING	401,391	11,387	20,595	77,662	28,014 9.00
10.00	01000	DIETARY	146,505	82,106	148,503	25,606	56,028 10.00
11.00	01100	CAFETERIA	214,686	8,171	14,778	59,812	0 11.00
13.00	01300	NURSING ADMINISTRATION	1,219,296	39,967	72,287	292,425	65,366 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	34,650	8,119	14,684	8,877	0 14.00
15.00	01500	PHARMACY	8,735,861	16,098	29,116	127,111	56,028 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	19,345	80,716	145,988	6,773	37,352 16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,144,958	147,159	266,162	439,792	112,056 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,274,244	223,911	404,981	541,605	672,334 50.00
51.00	05100	RECOVERY ROOM	150,377	24,703	44,680	37,519	28,014 51.00
53.00	05300	ANESTHESIOLOGY	45,681	1,356	2,453	0	46,690 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,794,340	89,286	161,489	273,688	158,746 54.00
60.00	06000	LABORATORY	1,928,982	40,819	73,827	179,508	168,084 60.00
64.00	06400	INTRAVENOUS THERAPY	1,027,630	48,329	87,410	205,155	196,098 64.00
65.00	06500	RESPIRATORY THERAPY	499,398	11,422	20,658	112,496	84,042 65.00
65.01	03610	SLEEP LAB	833,939	50,363	91,089	162,364	373,520 65.01
65.02	03620	GERIATRIC PSYCH	409,287	21,035	38,046	0	46,690 65.02
66.00	06600	PHYSICAL THERAPY	1,291,799	20,861	37,731	222,028	168,084 66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,395,062	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,805,123	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	205,360	0	0	0	0 73.00
76.97	07697	CARDIAC REHABILITATION	330,443	32,891	59,489	78,815	65,366 76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	477,532	44,417	80,336	58,759	121,394 90.00
91.00	09100	EMERGENCY	1,446,481	82,524	149,258	291,612	158,746 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	48,492,579	1,658,071	2,998,901	3,693,012	3,324,326 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,597	13,740	0	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	19,958	15,455	27,952	0	0 192.00
192.01	19201	UNUSED SPACE	0	8,205	14,841	0	0 192.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	48,512,537	1,689,328	3,055,434	3,693,012	3,324,326 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1334

Period:
From 04/01/2019
To 03/31/2020Worksheet B
Part I
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Cost Center Description			PURCHASING RECEIVING AND STORES	CASHIERING/ACC OUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.02	5.03	5A.03	5.04	6.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	91,312					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	693	1,740,075				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	39	0	5,685,893	5,685,893		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	1,535,829	203,904	1,739,733	6.00
7.00	00700	OPERATION OF PLANT	0	0	331,080	43,956	36,083	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	295,503	39,232	17,687	8.00
9.00	00900	HOUSEKEEPING	2	0	539,051	71,567	17,188	9.00
10.00	01000	DIETARY	19	0	458,767	60,908	123,940	10.00
11.00	01100	CAFETERIA	43	0	297,490	39,496	12,334	11.00
13.00	01300	NURSING ADMINISTRATION	101	0	1,689,442	224,299	60,330	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1	0	66,331	8,806	12,255	14.00
15.00	01500	PHARMACY	2,186	0	8,966,400	1,190,438	24,300	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	290,174	38,525	121,841	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,374	25,414	3,143,915	417,402	222,138	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	47,950	404,743	5,569,768	739,470	337,996	50.00
51.00	05100	RECOVERY ROOM	146	17,966	303,405	40,282	37,290	51.00
53.00	05300	ANESTHESIOLOGY	1,980	57,563	155,723	20,675	2,047	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,666	356,059	2,837,274	376,691	134,778	54.00
60.00	06000	LABORATORY	5,944	271,294	2,668,458	354,278	61,616	60.00
64.00	06400	INTRAVENOUS THERAPY	8,742	36,595	1,609,959	213,746	72,952	64.00
65.00	06500	RESPIRATORY THERAPY	782	32,400	761,198	101,060	17,241	65.00
65.01	03610	SLEEP LAB	377	69,690	1,581,342	209,947	76,023	65.01
65.02	03620	GERIATRIC PSYCH	8	3,574	518,640	68,857	31,753	65.02
66.00	06600	PHYSICAL THERAPY	275	55,349	1,796,127	238,463	31,490	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	39,268	1,434,330	190,429	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	44,464	1,849,587	245,560	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	207,674	413,034	54,836	0	73.00
76.97	07697	CARDIAC REHABILITATION	191	9,015	576,210	76,501	49,650	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,743	24,510	808,691	107,366	67,048	90.00
91.00	09100	EMERGENCY	8,050	84,497	2,221,168	294,893	124,570	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	91,312	1,740,075	48,404,789	5,671,587	1,692,550	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	21,337	2,833	11,468	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	63,365	8,413	23,329	192.00
192.01	19201	UNUSED SPACE	0	0	23,046	3,060	12,386	192.01
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	91,312	1,740,075	48,512,537	5,685,893	1,739,733	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1334

Period:
From 04/01/2019
To 03/31/2020Worksheet B
Part I
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Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	411,119					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,268	356,690				8.00
9.00	00900	HOUSEKEEPING	4,148	215	632,169			9.00
10.00	01000	DIETARY	29,909	47	0	673,571		10.00
11.00	01100	CAFETERIA	2,976	0	7,296	0	359,592	11.00
13.00	01300	NURSING ADMINISTRATION	14,559	0	0	0	27,021	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,957	0	0	0	2,079	14.00
15.00	01500	PHARMACY	5,864	0	4,377	0	10,393	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	29,402	0	1,459	0	2,079	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	53,605	101,336	166,828	673,571	56,121	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	81,564	78,191	147,859	0	66,515	50.00
51.00	05100	RECOVERY ROOM	8,999	26,908	8,147	0	4,157	51.00
53.00	05300	ANESTHESIOLOGY	494	0	851	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	32,524	35,016	29,183	0	35,336	54.00
60.00	06000	LABORATORY	14,869	0	9,971	0	27,021	60.00
64.00	06400	INTRAVENOUS THERAPY	17,605	0	43,774	0	22,864	64.00
65.00	06500	RESPIRATORY THERAPY	4,161	1,200	4,377	0	12,471	65.00
65.01	03610	SLEEP LAB	18,346	513	40,126	0	22,864	65.01
65.02	03620	GERIATRIC PSYCH	7,662	0	14,591	0	0	65.02
66.00	06600	PHYSICAL THERAPY	7,599	0	0	0	24,943	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	11,981	1,060	21,887	0	10,393	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	16,180	8,923	28,088	0	8,314	90.00
91.00	09100	EMERGENCY	30,061	103,281	103,355	0	27,021	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	399,733	356,690	632,169	673,571	359,592	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,767	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,630	0	0	0	0	192.00
192.01	19201	UNUSED SPACE	2,989	0	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	411,119	356,690	632,169	673,571	359,592	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1334

Period:
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Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			13.00	14.00	15.00	16.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	2,015,651					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	92,428				14.00
15.00	01500	PHARMACY	125,802	0	10,327,574			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	483,480		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	698,160	108	44,902	7,060	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	807,708	88,645	56,083	112,506	0	50.00
51.00	05100	RECOVERY ROOM	41,157	0	1,037	4,991	0	51.00
53.00	05300	ANESTHESIOLOGY	0	499	6,327	15,992	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	3,034	98,918	0	54.00
60.00	06000	LABORATORY	0	0	0	75,369	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	148	29,816	10,167	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,216	0	9,001	0	65.00
65.01	03610	SLEEP LAB	0	0	0	19,361	0	65.01
65.02	03620	GERIATRIC PSYCH	0	0	0	993	0	65.02
66.00	06600	PHYSICAL THERAPY	0	0	0	15,377	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	10,909	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,353	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	10,165,108	57,695	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	2,504	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	380	8,584	6,809	0	90.00
91.00	09100	EMERGENCY	342,824	432	12,683	23,475	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,015,651	92,428	10,327,574	483,480	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	UNUSED SPACE	0	0	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,015,651	92,428	10,327,574	483,480	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1334

Period:
From 04/01/2019
To 03/31/2020Worksheet B
Part I
Date/Time Prepared:
8/18/2020 2:52 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00550	DATA PROCESSING				5.01
5.02	00560	PURCHASING RECEIVING AND STORES				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL				5.04
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,585,146	0	5,585,146	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,086,305	0	8,086,305	50.00
51.00	05100	RECOVERY ROOM	476,373	0	476,373	51.00
53.00	05300	ANESTHESIOLOGY	202,608	0	202,608	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,582,754	0	3,582,754	54.00
60.00	06000	LABORATORY	3,211,582	0	3,211,582	60.00
64.00	06400	INTRAVENOUS THERAPY	2,021,031	0	2,021,031	64.00
65.00	06500	RESPIRATORY THERAPY	912,925	0	912,925	65.00
65.01	03610	SLEEP LAB	1,968,522	0	1,968,522	65.01
65.02	03620	GERIATRIC PSYCH	642,496	0	642,496	65.02
66.00	06600	PHYSICAL THERAPY	2,113,999	0	2,113,999	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,635,668	0	1,635,668	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,107,500	0	2,107,500	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,690,673	0	10,690,673	73.00
76.97	07697	CARDIAC REHABILITATION	750,186	0	750,186	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,060,383	0	1,060,383	90.00
91.00	09100	EMERGENCY	3,283,763	0	3,283,763	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	48,331,914	0	48,331,914	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	38,405	0	38,405	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	100,737	0	100,737	192.00
192.01	19201	UNUSED SPACE	41,481	0	41,481	192.01
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	48,512,537	0	48,512,537	202.00

COST ALLOCATION STATISTICS

Provider CCN: 14-1334

Period:

From 04/01/2019

To 03/31/2020

Worksheet Non-CMS W

Date/Time Prepared:
8/18/2020 2:52 pm

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	2	GROSS SALARIES	4.00
5.01	DATA PROCESSING	3	NUMBER OF PCS	5.01
5.02	PURCHASING RECEIVING AND STORES	4	PURCHASING SUPPLIES	5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE	5	GROSS REVENUE	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	-5	ACCUM. COST	5.04
6.00	MAINTENANCE & REPAIRS	1	SQUARE FEET	6.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	6	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	7	HOURS OF SERVICE	9.00
10.00	DIETARY	8	MEALS SERVED	10.00
11.00	CAFETERIA	9	NUMBER OF FTES	11.00
13.00	NURSING ADMINISTRATION	10	DIRECT NURS. HRS.	13.00
14.00	CENTRAL SERVICES & SUPPLY	11	COSTED REQUIS.	14.00
15.00	PHARMACY	12	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	5	GROSS REVENUE	16.00
19.00	NONPHYSICIAN ANESTHETISTS	13	ASSIGNED TIME	19.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1334

Period:
From 04/01/2019
To 03/31/2020Worksheet B
Part II
Date/Time Prepared:
8/18/2020 2:52 pm

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	15,785	28,550	44,335	4.00
5.01	00550	DATA PROCESSING	0	7,527	13,615	21,142	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	7,441	13,457	20,898	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	22,339	40,404	62,743	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	335,342	606,526	941,868	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	148,376	268,363	416,739	6.00
7.00	00700	OPERATION OF PLANT	0	23,904	43,234	67,138	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	11,717	21,192	32,909	8.00
9.00	00900	HOUSEKEEPING	0	11,387	20,595	31,982	9.00
10.00	01000	DIETARY	0	82,106	148,503	230,609	10.00
11.00	01100	CAFETERIA	0	8,171	14,778	22,949	11.00
13.00	01300	NURSING ADMINISTRATION	0	39,967	72,287	112,254	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8,119	14,684	22,803	14.00
15.00	01500	PHARMACY	0	16,098	29,116	45,214	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	80,716	145,988	226,704	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	147,159	266,162	413,321	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	223,911	404,981	628,892	50.00
51.00	05100	RECOVERY ROOM	0	24,703	44,680	69,383	51.00
53.00	05300	ANESTHESIOLOGY	0	1,356	2,453	3,809	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	89,286	161,489	250,775	54.00
60.00	06000	LABORATORY	0	40,819	73,827	114,646	60.00
64.00	06400	INTRAVENOUS THERAPY	0	48,329	87,410	135,739	64.00
65.00	06500	RESPIRATORY THERAPY	0	11,422	20,658	32,080	65.00
65.01	03610	SLEEP LAB	0	50,363	91,089	141,452	65.01
65.02	03620	GERIATRIC PSYCH	0	21,035	38,046	59,081	65.02
66.00	06600	PHYSICAL THERAPY	0	20,861	37,731	58,592	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	32,891	59,489	92,380	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	44,417	80,336	124,753	90.00
91.00	09100	EMERGENCY	0	82,524	149,258	231,782	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,658,071	2,998,901	4,656,972	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,597	13,740	21,337	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	15,455	27,952	43,407	192.00
192.01	19201	UNUSED SPACE	0	8,205	14,841	23,046	192.01
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,689,328	3,055,434	4,744,762	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1334

Period:
From 04/01/2019
To 03/31/2020Worksheet B
Part II
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Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	CASHIERING/ACC OUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.01	5.02	5.03	5.04	6.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING	21,142					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	59	21,083				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	950	160	65,689			5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	2,197	9	0	946,505		5.04
6.00	00600	MAINTENANCE & REPAIRS	950	0	0	33,943	452,603	6.00
7.00	00700	OPERATION OF PLANT	178	0	0	7,317	9,387	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	6,531	4,601	8.00
9.00	00900	HOUSEKEEPING	178	0	0	11,914	4,472	9.00
10.00	01000	DIETARY	356	4	0	10,139	32,244	10.00
11.00	01100	CAFETERIA	0	10	0	6,575	3,209	11.00
13.00	01300	NURSING ADMINISTRATION	416	23	0	37,338	15,695	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	1,466	3,188	14.00
15.00	01500	PHARMACY	356	505	0	198,160	6,322	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	238	0	0	6,413	31,698	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	713	1,934	959	69,484	57,791	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,276	11,071	15,280	123,097	87,932	50.00
51.00	05100	RECOVERY ROOM	178	34	678	6,706	9,701	51.00
53.00	05300	ANESTHESIOLOGY	297	457	2,173	3,442	533	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,010	847	13,442	62,707	35,063	54.00
60.00	06000	LABORATORY	1,069	1,372	10,242	58,976	16,030	60.00
64.00	06400	INTRAVENOUS THERAPY	1,247	2,019	1,381	35,582	18,979	64.00
65.00	06500	RESPIRATORY THERAPY	534	181	1,223	16,823	4,485	65.00
65.01	03610	SLEEP LAB	2,376	87	2,631	34,949	19,778	65.01
65.02	03620	GERIATRIC PSYCH	297	2	135	11,462	8,261	65.02
66.00	06600	PHYSICAL THERAPY	1,069	63	2,089	39,696	8,192	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,482	31,700	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,679	40,878	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	7,840	9,128	0	73.00
76.97	07697	CARDIAC REHABILITATION	416	44	340	12,735	12,917	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	772	402	925	17,873	17,443	90.00
91.00	09100	EMERGENCY	1,010	1,859	3,190	49,090	32,408	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,142	21,083	65,689	944,124	440,329	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	472	2,983	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,400	6,069	192.00
192.01	19201	UNUSED SPACE	0	0	0	509	3,222	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	21,142	21,083	65,689	946,505	452,603	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1334

Period:
From 04/01/2019
To 03/31/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	84,557					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	878	44,919				8.00
9.00	00900	HOUSEKEEPING	853	27	50,358			9.00
10.00	01000	DIETARY	6,152	6	0	279,817		10.00
11.00	01100	CAFETERIA	612	0	581	0	34,654	11.00
13.00	01300	NURSING ADMINISTRATION	2,994	0	0	0	2,604	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	608	0	0	0	200	14.00
15.00	01500	PHARMACY	1,206	0	349	0	1,002	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,047	0	116	0	200	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,025	12,762	13,291	279,817	5,408	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	16,776	9,847	11,778	0	6,411	50.00
51.00	05100	RECOVERY ROOM	1,851	3,389	649	0	401	51.00
53.00	05300	ANESTHESIOLOGY	102	0	68	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,689	4,410	2,325	0	3,405	54.00
60.00	06000	LABORATORY	3,058	0	794	0	2,604	60.00
64.00	06400	INTRAVENOUS THERAPY	3,621	0	3,487	0	2,203	64.00
65.00	06500	RESPIRATORY THERAPY	856	151	349	0	1,202	65.00
65.01	03610	SLEEP LAB	3,773	65	3,196	0	2,203	65.01
65.02	03620	GERIATRIC PSYCH	1,576	0	1,162	0	0	65.02
66.00	06600	PHYSICAL THERAPY	1,563	0	0	0	2,404	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	2,464	133	1,743	0	1,002	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,328	1,124	2,237	0	801	90.00
91.00	09100	EMERGENCY	6,183	13,005	8,233	0	2,604	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	82,215	44,919	50,358	279,817	34,654	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	569	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,158	0	0	0	0	192.00
192.01	19201	UNUSED SPACE	615	0	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	84,557	44,919	50,358	279,817	34,654	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1334

Period:
From 04/01/2019
To 03/31/2020Worksheet B
Part II
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Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			13.00	14.00	15.00	16.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	174,835					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	28,372				14.00
15.00	01500	PHARMACY	10,912	0	265,552			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	271,497		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	60,558	33	1,155	3,966		30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	70,059	27,210	1,442	63,111		50.00
51.00	05100	RECOVERY ROOM	3,570	0	27	2,804		51.00
53.00	05300	ANESTHESIOLOGY	0	153	163	8,983		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	78	55,565		54.00
60.00	06000	LABORATORY	0	0	0	42,337		60.00
64.00	06400	INTRAVENOUS THERAPY	0	46	767	5,711		64.00
65.00	06500	RESPIRATORY THERAPY	0	680	0	5,056		65.00
65.01	03610	SLEEP LAB	0	0	0	10,875		65.01
65.02	03620	GERIATRIC PSYCH	0	0	0	558		65.02
66.00	06600	PHYSICAL THERAPY	0	0	0	8,637		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,128		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,939		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	261,373	32,409		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,407		76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	117	221	3,825		90.00
91.00	09100	EMERGENCY	29,736	133	326	13,186		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	174,835	28,372	265,552	271,497	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	19201	UNUSED SPACE	0	0	0	0		192.01
200.00		Cross Foot Adjustments						0 200.00
201.00		Negative Cost Centers	0	0	0	0		0 201.00
202.00		TOTAL (sum lines 118 through 201)	174,835	28,372	265,552	271,497	0	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1334

Period:
From 04/01/2019
To 03/31/2020Worksheet B
Part II
Date/Time Prepared:
8/18/2020 2:52 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00550	DATA PROCESSING				5.01
5.02	00560	PURCHASING RECEIVING AND STORES				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL				5.04
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	937,498	0	937,498	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,083,680	0	1,083,680	50.00
51.00	05100	RECOVERY ROOM	99,821	0	99,821	51.00
53.00	05300	ANESTHESIOLOGY	20,180	0	20,180	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	439,602	0	439,602	54.00
60.00	06000	LABORATORY	253,283	0	253,283	60.00
64.00	06400	INTRAVENOUS THERAPY	213,245	0	213,245	64.00
65.00	06500	RESPIRATORY THERAPY	64,971	0	64,971	65.00
65.01	03610	SLEEP LAB	223,334	0	223,334	65.01
65.02	03620	GERIATRIC PSYCH	82,534	0	82,534	65.02
66.00	06600	PHYSICAL THERAPY	124,971	0	124,971	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	39,310	0	39,310	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	49,496	0	49,496	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	310,750	0	310,750	73.00
76.97	07697	CARDIAC REHABILITATION	126,527	0	126,527	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	174,527	0	174,527	90.00
91.00	09100	EMERGENCY	396,246	0	396,246	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,639,975	0	4,639,975	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	25,361	0	25,361	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	52,034	0	52,034	192.00
192.01	19201	UNUSED SPACE	27,392	0	27,392	192.01
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,744,762	0	4,744,762	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1334

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

Worksheet B-1

Date/Time Prepared:
8/18/2020 2:52 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (NUMBER OF PCS)	PURCHASING RECEIVING AND STORES (PURCHASING SUPPLIES)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	97,175					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		97,175				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	908	908	14,410,579			4.00
5.01	00550	DATA PROCESSING	433	433	0	356		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	428	428	40,919	1	1,674,739	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,285	1,285	596,562	16	12,705	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	19,290	19,290	790,066	37	723	5.04
6.00	00600	MAINTENANCE & REPAIRS	8,535	8,535	315,522	16	0	6.00
7.00	00700	OPERATION OF PLANT	1,375	1,375	174,452	3	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	674	674	0	0	0	8.00
9.00	00900	HOUSEKEEPING	655	655	303,048	3	29	9.00
10.00	01000	DIETARY	4,723	4,723	99,917	6	341	10.00
11.00	01100	CAFETERIA	470	470	233,394	0	797	11.00
13.00	01300	NURSING ADMINISTRATION	2,299	2,299	1,141,079	7	1,859	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	467	467	34,639	0	11	14.00
15.00	01500	PHARMACY	926	926	496,002	6	40,100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,643	4,643	26,430	4	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,465	8,465	1,716,121	12	153,588	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,880	12,880	2,113,413	72	879,419	50.00
51.00	05100	RECOVERY ROOM	1,421	1,421	146,405	3	2,681	51.00
53.00	05300	ANESTHESIOLOGY	78	78	0	5	36,319	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,136	5,136	1,067,963	17	67,244	54.00
60.00	06000	LABORATORY	2,348	2,348	700,462	18	109,023	60.00
64.00	06400	INTRAVENOUS THERAPY	2,780	2,780	800,540	21	160,340	64.00
65.00	06500	RESPIRATORY THERAPY	657	657	438,972	9	14,348	65.00
65.01	03610	SLEEP LAB	2,897	2,897	633,562	40	6,913	65.01
65.02	03620	GERIATRIC PSYCH	1,210	1,210	0	5	138	65.02
66.00	06600	PHYSICAL THERAPY	1,200	1,200	866,378	18	5,044	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	1,892	1,892	307,544	7	3,500	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,555	2,555	229,284	13	31,970	90.00
91.00	09100	EMERGENCY	4,747	4,747	1,137,905	17	147,647	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	95,377	95,377	14,410,579	356	1,674,739	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	437	437	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	889	889	0	0	0	192.00
192.01	19201	UNUSED SPACE	472	472	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,689,328	3,055,434	3,693,012	3,324,326	91,312	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	17.384389	31.442593	0.256271	9,337.994382	0.054523	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			44,335	21,142	21,083	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.003077	59.387640	0.012589	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1334

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

Worksheet B-1

Date/Time Prepared:
8/18/2020 2:52 pm

Cost Center Description			CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	
			5.03	5A.04	5.04	6.00	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	231,302,543					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	-5,685,893	42,826,644			5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	1,535,829	66,296		6.00
7.00	00700	OPERATION OF PLANT	0	0	331,080	1,375	64,921	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	295,503	674	674	8.00
9.00	00900	HOUSEKEEPING	0	0	539,051	655	655	9.00
10.00	01000	DIETARY	0	0	458,767	4,723	4,723	10.00
11.00	01100	CAFETERIA	0	0	297,490	470	470	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,689,442	2,299	2,299	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	66,331	467	467	14.00
15.00	01500	PHARMACY	0	0	8,966,400	926	926	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	290,174	4,643	4,643	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,378,110	0	3,143,915	8,465	8,465	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	53,802,762	0	5,569,768	12,880	12,880	50.00
51.00	05100	RECOVERY ROOM	2,388,143	0	303,405	1,421	1,421	51.00
53.00	05300	ANESTHESIOLOGY	7,651,597	0	155,723	78	78	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	47,329,365	0	2,837,274	5,136	5,136	54.00
60.00	06000	LABORATORY	36,061,902	0	2,668,458	2,348	2,348	60.00
64.00	06400	INTRAVENOUS THERAPY	4,864,382	0	1,609,959	2,780	2,780	64.00
65.00	06500	RESPIRATORY THERAPY	4,306,844	0	761,198	657	657	65.00
65.01	03610	SLEEP LAB	9,263,575	0	1,581,342	2,897	2,897	65.01
65.02	03620	GERIATRIC PSYCH	475,104	0	518,640	1,210	1,210	65.02
66.00	06600	PHYSICAL THERAPY	7,357,283	0	1,796,127	1,200	1,200	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,219,700	0	1,434,330	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,910,361	0	1,849,587	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,605,237	0	413,034	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	1,198,261	0	576,210	1,892	1,892	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,258,057	0	808,691	2,555	2,555	90.00
91.00	09100	EMERGENCY	11,231,860	0	2,221,168	4,747	4,747	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	231,302,543	-5,685,893	42,718,896	64,498	63,123	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	21,337	437	437	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	63,365	889	889	192.00
192.01	19201	UNUSED SPACE	0	0	23,046	472	472	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,740,075		5,685,893	1,739,733	411,119	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.007523		0.132765	26.241900	6.332604	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	65,689		946,505	452,603	84,557	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000284		0.022101	6.827003	1.302460	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1334

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

Worksheet B-1

Date/Time Prepared:
8/18/2020 2:52 pm

Cost Center Description			LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER OF FTES)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
			8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	61,242					8.00
9.00	00900	HOUSEKEEPING	37	5,199				9.00
10.00	01000	DIETARY	8	0	16,797			10.00
11.00	01100	CAFETERIA	0	60	0	173		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	13	164,310	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	1	0	14.00
15.00	01500	PHARMACY	0	36	0	5	10,255	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12	0	1	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,399	1,372	16,797	27	56,912	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	13,425	1,216	0	32	65,842	50.00
51.00	05100	RECOVERY ROOM	4,620	67	0	2	3,355	51.00
53.00	05300	ANESTHESIOLOGY	0	7	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,012	240	0	17	0	54.00
60.00	06000	LABORATORY	0	82	0	13	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	360	0	11	0	64.00
65.00	06500	RESPIRATORY THERAPY	206	36	0	6	0	65.00
65.01	03610	SLEEP LAB	88	330	0	11	0	65.01
65.02	03620	GERIATRIC PSYCH	0	120	0	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0	0	0	12	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	182	180	0	5	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,532	231	0	4	0	90.00
91.00	09100	EMERGENCY	17,733	850	0	13	27,946	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	61,242	5,199	16,797	173	164,310	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	UNUSED SPACE	0	0	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	356,690	632,169	673,571	359,592	2,015,651	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.824271	121.594345	40.100673	2,078.566474	12.267367	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	44,919	50,358	279,817	34,654	174,835	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.733467	9.686093	16.658749	200.312139	1.064056	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1334

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

Worksheet B-1

Date/Time Prepared:
8/18/2020 2:52 pm

Cost Center Description			CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			14.00	15.00	16.00	19.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	DATA PROCESSING					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,394,889				14.00
15.00	01500	PHARMACY	0	8,070,536			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	231,302,543		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,630	35,089	3,378,110	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,337,770	43,826	53,802,762	0	50.00
51.00	05100	RECOVERY ROOM	7	810	2,388,143	0	51.00
53.00	05300	ANESTHESIOLOGY	7,538	4,944	7,651,597	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,371	47,329,365	0	54.00
60.00	06000	LABORATORY	0	0	36,061,902	0	60.00
64.00	06400	INTRAVENOUS THERAPY	2,237	23,300	4,864,382	0	64.00
65.00	06500	RESPIRATORY THERAPY	33,444	0	4,306,844	0	65.00
65.01	03610	SLEEP LAB	0	0	9,263,575	0	65.01
65.02	03620	GERIATRIC PSYCH	0	0	475,104	0	65.02
66.00	06600	PHYSICAL THERAPY	0	0	7,357,283	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	5,219,700	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	5,910,361	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,943,577	27,605,237	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	1,198,261	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	5,739	6,708	3,258,057	0	90.00
91.00	09100	EMERGENCY	6,524	9,911	11,231,860	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,394,889	8,070,536	231,302,543	100	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	UNUSED SPACE	0	0	0	0	192.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	92,428	10,327,574	483,480	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.066262	1.279664	0.002090	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	28,372	265,552	271,497	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.020340	0.032904	0.001174	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1334

Period:
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To 03/31/2020Worksheet C
Part I
Date/Time Prepared:
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			Title XVIII		Hospital		Cost		
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,585,146		5,585,146	0	0	30.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,086,305		8,086,305	0	0	50.00	
51.00	05100	RECOVERY ROOM	476,373		476,373	0	0	51.00	
53.00	05300	ANESTHESIOLOGY	202,608		202,608	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,582,754		3,582,754	0	0	54.00	
60.00	06000	LABORATORY	3,211,582		3,211,582	0	0	60.00	
64.00	06400	INTRAVENOUS THERAPY	2,021,031		2,021,031	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	912,925	0	912,925	0	0	65.00	
65.01	03610	SLEEP LAB	1,968,522	0	1,968,522	0	0	65.01	
65.02	03620	GERIATRIC PSYCH	642,496	0	642,496	0	0	65.02	
66.00	06600	PHYSICAL THERAPY	2,113,999	0	2,113,999	0	0	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,635,668		1,635,668	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,107,500		2,107,500	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	10,690,673		10,690,673	0	0	73.00	
76.97	07697	CARDIAC REHABILITATION	750,186		750,186	0	0	76.97	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,060,383		1,060,383	0	0	90.00	
91.00	09100	EMERGENCY	3,283,763		3,283,763	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	528,673		528,673	0	0	92.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	48,860,587	0	48,860,587	0	0	200.00	
201.00		Less Observation Beds	528,673		528,673			201.00	
202.00		Total (see instructions)	48,331,914	0	48,331,914	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1334

Period:
From 04/01/2019
To 03/31/2020Worksheet C
Part I
Date/Time Prepared:
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			Title XVIII			Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,679,974		2,679,974			30.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	493,694	51,902,951	52,396,645	0.154329	0.000000	50.00	
51.00	05100	RECOVERY ROOM	62,033	1,951,580	2,013,613	0.236576	0.000000	51.00	
53.00	05300	ANESTHESIOLOGY	88,124	7,279,402	7,367,526	0.027500	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	929,563	45,024,108	45,953,671	0.077964	0.000000	54.00	
60.00	06000	LABORATORY	1,184,670	33,447,287	34,631,957	0.092735	0.000000	60.00	
64.00	06400	INTRAVENOUS THERAPY	93,480	4,636,677	4,730,157	0.427265	0.000000	64.00	
65.00	06500	RESPIRATORY THERAPY	1,089,825	3,166,803	4,256,628	0.214471	0.000000	65.00	
65.01	03610	SLEEP LAB	0	8,781,335	8,781,335	0.224171	0.000000	65.01	
65.02	03620	GERIATRIC PSYCH	0	475,104	475,104	1.352327	0.000000	65.02	
66.00	06600	PHYSICAL THERAPY	1,919,937	5,295,275	7,215,212	0.292992	0.000000	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	66,470	5,061,704	5,128,174	0.318957	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	76,802	5,757,142	5,833,944	0.361248	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	2,064,950	24,472,015	26,536,965	0.402860	0.000000	73.00	
76.97	07697	CARDIAC REHABILITATION	507	1,196,701	1,197,208	0.626613	0.000000	76.97	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,681	3,206,993	3,210,674	0.330268	0.000000	90.00	
91.00	09100	EMERGENCY	230,016	10,806,320	11,036,336	0.297541	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	22,837	669,515	692,352	0.763590	0.000000	92.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	11,006,563	213,130,912	224,137,475			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	11,006,563	213,130,912	224,137,475			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1334

Period:
From 04/01/2019
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
65.01	03610 SLEEP LAB	0.000000			65.01
65.02	03620 GERIATRIC PSYCH	0.000000			65.02
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

Worksheet C
Part I
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COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1334

Period:
From 04/01/2019
To 03/31/2020Worksheet C
Part I
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			Title XIX			Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,679,974		2,679,974			30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	493,694	51,902,951	52,396,645	0.154329	0.000000	50.00
51.00	05100	RECOVERY ROOM	62,033	1,951,580	2,013,613	0.236576	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	88,124	7,279,402	7,367,526	0.027500	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	929,563	45,024,108	45,953,671	0.077964	0.000000	54.00
60.00	06000	LABORATORY	1,184,670	33,447,287	34,631,957	0.092735	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	93,480	4,636,677	4,730,157	0.427265	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,089,825	3,166,803	4,256,628	0.214471	0.000000	65.00
65.01	03610	SLEEP LAB	0	8,781,335	8,781,335	0.224171	0.000000	65.01
65.02	03620	GERIATRIC PSYCH	0	475,104	475,104	1.352327	0.000000	65.02
66.00	06600	PHYSICAL THERAPY	1,919,937	5,295,275	7,215,212	0.292992	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	66,470	5,061,704	5,128,174	0.318957	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	76,802	5,757,142	5,833,944	0.361248	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,064,950	24,472,015	26,536,965	0.402860	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	507	1,196,701	1,197,208	0.626613	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	3,681	3,206,993	3,210,674	0.330268	0.000000	90.00
91.00	09100	EMERGENCY	230,016	10,806,320	11,036,336	0.297541	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	22,837	669,515	692,352	0.763590	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	11,006,563	213,130,912	224,137,475			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	11,006,563	213,130,912	224,137,475			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1334

Period:
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To 03/31/2020Worksheet C
Part I
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Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
65.01	03610 SLEEP LAB	0.000000			65.01
65.02	03620 GERIATRIC PSYCH	0.000000			65.02
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-1334	Period: From 04/01/2019 To 03/31/2020	Worksheet D Part II Date/Time Prepared: 8/18/2020 2:52 pm	
				Title XVIII		Hospital	Cost
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,083,680	52,396,645	0.020682	212,134	4,387
51.00	05100	RECOVERY ROOM	99,821	2,013,613	0.049573	38,020	1,885
53.00	05300	ANESTHESIOLOGY	20,180	7,367,526	0.002739	36,359	100
54.00	05400	RADIOLOGY-DIAGNOSTIC	439,602	45,953,671	0.009566	364,351	3,485
60.00	06000	LABORATORY	253,283	34,631,957	0.007314	352,598	2,579
64.00	06400	INTRAVENOUS THERAPY	213,245	4,730,157	0.045082	17,440	786
65.00	06500	RESPIRATORY THERAPY	64,971	4,256,628	0.015263	169,525	2,587
65.01	03610	SLEEP LAB	223,334	8,781,335	0.025433	0	0
65.02	03620	GERIATRIC PSYCH	82,534	475,104	0.173718	0	0
66.00	06600	PHYSICAL THERAPY	124,971	7,215,212	0.017320	104,131	1,804
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	39,310	5,128,174	0.007665	46,731	358
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	49,496	5,833,944	0.008484	1,633	14
73.00	07300	DRUGS CHARGED TO PATIENTS	310,750	26,536,965	0.011710	401,196	4,698
76.97	07697	CARDIAC REHABILITATION	126,527	1,197,208	0.105685	0	0
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	174,527	3,210,674	0.054358	2,079	113
91.00	09100	EMERGENCY	396,246	11,036,336	0.035904	3,579	129
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	88,741	692,352	0.128173	603	77
200.00		Total (lines 50 through 199)	3,791,218	221,457,501		1,750,379	23,002

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1334

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

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1334

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

Worksheet D
Part IV
Date/Time Prepared:
8/18/2020 2:52 pm

Cost Center Description			Title XVIII		Hospital	Cost	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)
			4.00	5.00	6.00	7.00	8.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	52,396,645	0.000000
51.00	05100	RECOVERY ROOM	0	0	0	2,013,613	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	7,367,526	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	45,953,671	0.000000
60.00	06000	LABORATORY	0	0	0	34,631,957	0.000000
64.00	06400	INTRAVENOUS THERAPY	0	0	0	4,730,157	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,256,628	0.000000
65.01	03610	SLEEP LAB	0	0	0	8,781,335	0.000000
65.02	03620	GERIATRIC PSYCH	0	0	0	475,104	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	7,215,212	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	5,128,174	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,833,944	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	26,536,965	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,197,208	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	3,210,674	0.000000
91.00	09100	EMERGENCY	0	0	0	11,036,336	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	692,352	0.000000
200.00		Total (lines 50 through 199)	0	0	0	221,457,501	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1334

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part IV
Date/Time Prepared:
8/18/2020 2:52 pm

Cost Center Description		Title XVIII			Hospital		Cost	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	212,134	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	38,020	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	36,359	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	364,351	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	352,598	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	17,440	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	169,525	0	0	0	65.00
65.01	03610	SLEEP LAB	0.000000	0	0	0	0	65.01
65.02	03620	GERIATRIC PSYCH	0.000000	0	0	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0.000000	104,131	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	46,731	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,633	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	401,196	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	2,079	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	3,579	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	603	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,750,379	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1334		Period: From 04/01/2019 To 03/31/2020		Worksheet D Part IV Date/Time Prepared: 8/18/2020 2:52 pm		
				Title XVIII		Hospital		Cost		
Cost Center Description				PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost					
				21.00	24.00					
ANCILLARY SERVICE COST CENTERS										
50.00	05000	OPERATING ROOM	0	0						50.00
51.00	05100	RECOVERY ROOM	0	0						51.00
53.00	05300	ANESTHESIOLOGY	0	0						53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0						54.00
60.00	06000	LABORATORY	0	0						60.00
64.00	06400	INTRAVENOUS THERAPY	0	0						64.00
65.00	06500	RESPIRATORY THERAPY	0	0						65.00
65.01	03610	SLEEP LAB	0	0						65.01
65.02	03620	GERIATRIC PSYCH	0	0						65.02
66.00	06600	PHYSICAL THERAPY	0	0						66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0						71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0						72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0						73.00
76.97	07697	CARDIAC REHABILITATION	0	0						76.97
OUTPATIENT SERVICE COST CENTERS										
90.00	09000	CLINIC	0	0						90.00
91.00	09100	EMERGENCY	0	0						91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0						92.00
200.00		Total (lines 50 through 199)	0	0						200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1334

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part V
Date/Time Prepared:
8/18/2020 2:52 pm

				Title XVIII		Hospital		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.154329	0	16,262,680	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.236576	0	652,430	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.027500	0	2,274,237	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.077964	0	16,622,542	0	0	0	54.00
60.00	06000	LABORATORY	0.092735	0	10,206,879	292	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.427265	0	1,910,831	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.214471	0	1,138,237	0	0	0	65.00
65.01	03610	SLEEP LAB	0.224171	0	2,571,920	0	0	0	65.01
65.02	03620	GERIATRIC PSYCH	1.352327	0	331,607	0	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0.292992	0	1,672,416	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.318957	0	2,279,857	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.361248	0	2,515,341	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.402860	0	9,640,634	1,533	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.626613	0	410,402	0	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.330268	0	1,468,875	0	0	0	90.00
91.00	09100	EMERGENCY	0.297541	0	3,019,978	1,701	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.763590	0	407,057	0	0	0	92.00
200.00		Subtotal (see instructions)		0	73,385,923	3,526	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0			201.00
202.00		Net Charges (line 200 - line 201)		0	73,385,923	3,526	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1334

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part V
Date/Time Prepared:
8/18/2020 2:52 pm

			Title XVIII		Hospital	Cost
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,509,803	0		50.00
51.00	05100	RECOVERY ROOM	154,349	0		51.00
53.00	05300	ANESTHESIOLOGY	62,542	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,295,960	0		54.00
60.00	06000	LABORATORY	946,535	27		60.00
64.00	06400	INTRAVENOUS THERAPY	816,431	0		64.00
65.00	06500	RESPIRATORY THERAPY	244,119	0		65.00
65.01	03610	SLEEP LAB	576,550	0		65.01
65.02	03620	GERIATRIC PSYCH	448,441	0		65.02
66.00	06600	PHYSICAL THERAPY	490,005	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	727,176	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	908,662	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,883,826	618		73.00
76.97	07697	CARDIAC REHABILITATION	257,163	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	485,122	0		90.00
91.00	09100	EMERGENCY	898,567	506		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	310,825	0		92.00
200.00		Subtotal (see instructions)	15,016,076	1,151		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	15,016,076	1,151		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1334

Period:

Worksheet D

Component CCN: 14-Z334

From 04/01/2019
To 03/31/2020Part V
Date/Time Prepared:
8/18/2020 2:52 pm

			Title XVIII		Swing Beds - SNF		Cost	
	Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00			
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.154329	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.236576	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.027500	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.077964	0	0	0	0	54.00
60.00	06000	LABORATORY	0.092735	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.427265	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.214471	0	0	0	0	65.00
65.01	03610	SLEEP LAB	0.224171	0	0	0	0	65.01
65.02	03620	GERIATRIC PSYCH	1.352327	0	0	0	0	65.02
66.00	06600	PHYSICAL THERAPY	0.292992	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.318957	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.361248	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.402860	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.626613	0	0	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.330268	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.297541	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.763590	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1334

Period:

Worksheet D

Component CCN: 14-Z334

From 04/01/2019
To 03/31/2020Part V
Date/Time Prepared:
8/18/2020 2:52 pm

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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1334	Period: From 04/01/2019 To 03/31/2020	Worksheet D-1 Date/Time Prepared: 8/18/2020 2:52 pm	
		Title XVIII	Hospital	Cost	
Cost Center Description				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,372	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,247	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)		853	4.00	
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		2,263	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)		625	6.00	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		178	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)		59	8.00	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		447	9.00	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		1,570	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)		594	11.00	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00	
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00	
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00	
15.00	Total nursery days (title V or XIX only)		0	15.00	
16.00	Nursery days (title V or XIX only)		0	16.00	
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00	
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00	
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		155.23	19.00	
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		155.23	20.00	
21.00	Total general inpatient routine service cost (see instructions)		5,585,146	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)		27,631	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)		9,159	25.00	
26.00	Total swing-bed cost (see instructions)		3,911,908	26.00	
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,673,238	27.00	
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00	
29.00	Private room charges (excluding swing-bed charges)		0	29.00	
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00	
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00	
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00	
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00	
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00	
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,673,238	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)		1,341.80	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		599,785	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)		599,785	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1334

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

Worksheet D-1

Date/Time Prepared:
8/18/2020 2:52 pm

Cost Center Description		Title XVIII		Hospital	Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					357,490 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					957,275 49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0 54.00
55.00	Target amount per discharge					0.00 55.00
56.00	Target amount (line 54 x line 55)					0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00	Bonus payment (see instructions)					0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00	Relief payment (see instructions)					0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					2,106,626 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					797,029 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					2,903,655 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)					394 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,341.81 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					528,673 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1334

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

Worksheet D-1

Date/Time Prepared:
8/18/2020 2:52 pm

		Title XVIII		Hospital		Cost	
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	937,498	5,585,146	0.167856	528,673	88,741	90.00
91.00	Nursing School cost	0	5,585,146	0.000000	528,673	0	91.00
92.00	Allied health cost	0	5,585,146	0.000000	528,673	0	92.00
93.00	All other Medical Education	0	5,585,146	0.000000	528,673	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1334	Period: From 04/01/2019 To 03/31/2020	Worksheet D-3 Date/Time Prepared: 8/18/2020 2:52 pm	
		Title XVIII	Hospital	Cost	
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		380,315		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.154329	212,134	32,738	50.00
51.00	05100 RECOVERY ROOM	0.236576	38,020	8,995	51.00
53.00	05300 ANESTHESIOLOGY	0.027500	36,359	1,000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.077964	364,351	28,406	54.00
60.00	06000 LABORATORY	0.092735	352,598	32,698	60.00
64.00	06400 INTRAVENOUS THERAPY	0.427265	17,440	7,452	64.00
65.00	06500 RESPIRATORY THERAPY	0.214471	169,525	36,358	65.00
65.01	03610 SLEEP LAB	0.224171	0	0	65.01
65.02	03620 GERIATRIC PSYCH	1.352327	0	0	65.02
66.00	06600 PHYSICAL THERAPY	0.292992	104,131	30,510	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.318957	46,731	14,905	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.361248	1,633	590	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.402860	401,196	161,626	73.00
76.97	07697 CARDIAC REHABILITATION	0.626613	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.330268	2,079	687	90.00
91.00	09100 EMERGENCY	0.297541	3,579	1,065	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.763590	603	460	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,750,379	357,490	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)		1,750,379		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1334 Component CCN: 14-Z334	Period: From 04/01/2019 To 03/31/2020	Worksheet D-3 Date/Time Prepared: 8/18/2020 2:52 pm	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.154329	996	154	50.00
51.00	05100 RECOVERY ROOM	0.236576	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.027500	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.077964	134,678	10,500	54.00
60.00	06000 LABORATORY	0.092735	251,854	23,356	60.00
64.00	06400 INTRAVENOUS THERAPY	0.427265	18,986	8,112	64.00
65.00	06500 RESPIRATORY THERAPY	0.214471	500,456	107,333	65.00
65.01	03610 SLEEP LAB	0.224171	0	0	65.01
65.02	03620 GERIATRIC PSYCH	1.352327	0	0	65.02
66.00	06600 PHYSICAL THERAPY	0.292992	1,203,538	352,627	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.318957	15,441	4,925	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.361248	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.402860	1,007,974	406,072	73.00
76.97	07697 CARDIAC REHABILITATION	0.626613	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.330268	1,602	529	90.00
91.00	09100 EMERGENCY	0.297541	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.763590	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		3,135,525	913,608	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		3,135,525		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1334 Component CCN: 14-Z334	Period: From 04/01/2019 To 03/31/2020	Worksheet D-3 Date/Time Prepared: 8/18/2020 2:52 pm	
Cost Center Description		Title XIX	Swing Beds - SNF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.154329	0	0	50.00
51.00	05100 RECOVERY ROOM	0.236576	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.027500	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.077964	0	0	54.00
60.00	06000 LABORATORY	0.092735	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.427265	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.214471	0	0	65.00
65.01	03610 SLEEP LAB	0.224171	0	0	65.01
65.02	03620 GERIATRIC PSYCH	1.352327	0	0	65.02
66.00	06600 PHYSICAL THERAPY	0.292992	0	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.318957	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.361248	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.402860	0	0	73.00
76.97	07697 CARDIAC REHABILITATION	0.626613	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.330268	0	0	90.00
91.00	09100 EMERGENCY	0.297541	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.763590	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1334	Period: From 04/01/2019 To 03/31/2020	Worksheet E Part B Date/Time Prepared: 8/18/2020 2:52 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			15,017,227 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	OPPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
4.01	Outlier reconciliation amount (see instructions)			0 4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			15,017,227 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (see instructions)			15,167,399 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			139,131 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			12,807,796 26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			2,220,472 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			2,220,472 30.00
31.00	Primary payer payments			539 31.00
32.00	Subtotal (line 30 minus line 31)			2,219,933 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			2,830,806 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			1,840,024 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			2,070,630 36.00
37.00	Subtotal (see instructions)			4,059,957 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)			4,059,957 40.00
40.01	Sequestration adjustment (see instructions)			81,199 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			2,791,003 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)			1,187,755 43.00
43.01	Balance due provider/program-PARHM (see instructions)			0 43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-1334

Period:
From 04/01/2019
To 03/31/2020Worksheet E
Part B
Date/Time Prepared:
8/18/2020 2:52 pm

Title XVIII

Hospital

Cost

Overrides

1.00

WORKSHEET OVERRIDE VALUES

112.00 Override of Ancillary service charges (line 12)

0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1334

Period:
From 04/01/2019
To 03/31/2020Worksheet E-1
Part I
Date/Time Prepared:
8/18/2020 2:52 pm

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		805,606		3,609,378	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02		03/25/2020	172,747		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		09/30/2019	225,667	09/30/2019	162,757	3.51
3.52			0	03/25/2020	655,618	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)		-52,920		-818,375	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)		752,686		2,791,003	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		68,119		1,187,755	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		820,805		3,978,758	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1334

Period:

Worksheet E-1

Component CCN: 14-Z334

From 04/01/2019
To 03/31/2020Part I
Date/Time Prepared:
8/18/2020 2:52 pm

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,496,349		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02		03/25/2020	541,492		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		09/30/2019	19,356		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)		522,136		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,018,485		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		326,419		0	6.02
7.00	Total Medicare program liability (see instructions)		3,692,066		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-1334	Period: From 04/01/2019 To 03/31/2020	Worksheet E-1 Part II Date/Time Prepared: 8/18/2020 2:52 pm
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1334

Period:

Worksheet E-2

Component CCN: 14-Z334

From 04/01/2019
To 03/31/2020Date/Time Prepared:
8/18/2020 2:52 pm

		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		2,932,692	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)		922,744	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)				3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		2,164	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		3,855,436	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		3,855,436	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		3,855,436	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		88,022	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		3,767,414	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		3,767,414	0	19.00
19.01	Sequestration adjustment (see instructions)		75,348	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
20.00	Interim payments		4,018,485	0	20.00
20.01	Interim payments-PARHM				20.01
21.00	Tentative settlement (for contractor use only)		0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)				21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		-326,419	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1334	Period: From 04/01/2019 To 03/31/2020	Worksheet E-2	
		Component CCN: 14-Z334		Date/Time Prepared: 8/18/2020 2:52 pm	
		Title XIX	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)		0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)		0		3.00
3.01	Nursing and allied health payment-PARHM (see instructions)				3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00		4.00
5.00	Program days		0		5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0		6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0		8.00
9.00	Primary payer payments (see instructions)		0		9.00
10.00	Subtotal (line 8 minus line 9)		0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0		11.00
12.00	Subtotal (line 10 minus line 11)		0		12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		0		13.00
14.00	80% of Part B costs (line 12 x 80%)		0		14.00
15.00	Subtotal (see instructions)		0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)				16.55
16.99	Demonstration payment adjustment amount before sequestration		0		16.99
17.00	Allowable bad debts (see instructions)		0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		18.00
19.00	Total (see instructions)		0		19.00
19.01	Sequestration adjustment (see instructions)		0		19.01
19.02	Demonstration payment adjustment amount after sequestration)		0		19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
20.00	Interim payments		0		20.00
20.01	Interim payments-PARHM				20.01
21.00	Tentative settlement (for contractor use only)		0		21.00
21.01	Tentative settlement-PARHM (for contractor use only)				21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		0		22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0		23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1334	Period: From 04/01/2019 To 03/31/2020	Worksheet E-3 Part V Date/Time Prepared: 8/18/2020 2:52 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		957,275	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		957,275	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		966,848	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		966,848	19.00
20.00	Deductibles (exclude professional component)		167,725	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		799,123	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		799,123	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		59,127	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		38,433	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		35,733	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		837,556	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		837,556	30.00
30.01	Sequestration adjustment (see instructions)		16,751	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM		0	30.03
31.00	Interim payments		752,686	31.00
31.01	Interim payments-PARHM		0	31.01
32.00	Tentative settlement (for contractor use only)		0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		0	32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		68,119	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		0	33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

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

Provider CCN: 14-1334

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

Worksheet G

Date/Time Prepared:
8/18/2020 2:52 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	5,693,236	0	32,765	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	39,889,937	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-29,809,055	0	0	0	6.00
7.00	Inventory	1,617,627	0	0	0	7.00
8.00	Prepaid expenses	85,444	0	0	0	8.00
9.00	Other current assets	227,200	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)	17,704,389	0	32,765	0	11.00
FIXED ASSETS						
12.00	Land	171,136	0	0	0	12.00
13.00	Land improvements	1,198,731	0	0	0	13.00
14.00	Accumulated depreciation	-844,628	0	0	0	14.00
15.00	Buildings	29,893,130	0	0	0	15.00
16.00	Accumulated depreciation	-16,022,275	0	0	0	16.00
17.00	Leasehold improvements	2,333	0	0	0	17.00
18.00	Accumulated depreciation	-19	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	148,889	0	0	0	21.00
22.00	Accumulated depreciation	-104,372	0	0	0	22.00
23.00	Major movable equipment	17,372,145	0	0	0	23.00
24.00	Accumulated depreciation	-11,624,234	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	244,901	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	20,435,737	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	301,915	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	20,287	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	322,202	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	38,462,328	0	32,765	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,383,754	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,722,075	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	296,345	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	2,238,349	0	0	0	43.00
44.00	Other current liabilities	353,565	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,994,088	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	15,001,668	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	275,532	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	15,277,200	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	22,271,288	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	16,191,040	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	32,765	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	16,191,040	0	32,765	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	38,462,328	0	32,765	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1334

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

Worksheet G-1

Date/Time Prepared:
8/18/2020 2:52 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		16,642,158		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,206,358				2.00
3.00	Total (sum of line 1 and line 2)		18,848,516		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	DONATION	0		0		3,145	5.00
6.00	EMS TRAUMA FUND	0		0		14,098	6.00
7.00	ICAHN FUNDS	0		0		13,866	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		18,848,516		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	EQUITY TRANSFER	2,179,833		0		0	13.00
14.00	UNREALIZED LOSS INTEREST SWAP	477,643		0		0	14.00
15.00		0		0		0	15.00
16.00	RESTRICTED FUND TRANSACTIONS	0		0		15,410	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		2,657,476		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		16,191,040		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	17,066		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)	17,066		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00	DONATION		0				5.00
6.00	EMS TRAUMA FUND		0				6.00
7.00	ICAHN FUNDS		0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	31,109		0			10.00
11.00	Subtotal (line 3 plus line 10)	48,175		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00	EQUITY TRANSFER		0				13.00
14.00	UNREALIZED LOSS INTEREST SWAP		0				14.00
15.00			0				15.00
16.00	RESTRICTED FUND TRANSACTIONS		0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	15,410		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	32,765		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1334

Period:
From 04/01/2019
To 03/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
8/18/2020 2:52 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,971,860		1,971,860	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	1,406,250		1,406,250	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,378,110		3,378,110	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,378,110		3,378,110	17.00
18.00	Ancillary services	8,301,226	219,623,206	227,924,432	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	11,679,336	219,623,206	231,302,542	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		48,975,087		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		48,975,087		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1334

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

Worksheet G-3

Date/Time Prepared:
8/18/2020 2:52 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	231,302,542	1.00
2.00	Less contractual allowances and discounts on patients' accounts	151,029,947	2.00
3.00	Net patient revenues (line 1 minus line 2)	80,272,595	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	48,975,087	4.00
5.00	Net income from service to patients (line 3 minus line 4)	31,297,508	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	20,243	6.00
7.00	Income from investments	-145,874	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	864	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	127,533	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	366	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	8,202	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	34,932	22.00
23.00	Governmental appropriations	15,410	23.00
24.00	MISCELLANEOUS	95	24.00
25.00	Total other income (sum of lines 6-24)	61,771	25.00
26.00	Total (line 5 plus line 25)	31,359,279	26.00
27.00	CORP ALLOC, CONTR TO AFF, LOSS ON EQ	29,152,921	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	29,152,921	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,206,358	29.00