

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: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet S Parts I-III Date/Time Prepared: 11/25/2019 10:38 am
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PART I - COST REPORT STATUS

Provider use only 1. Electronically filed cost report
 2. Manually submitted 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.

Date: 11/25/2019 Time: 10:38 am

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 MARION GENERAL HOSPITAL (15-0011) for the cost reporting period beginning 07/01/2018 and ending 06/30/2019 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	-193,279	-76,889	0	-398,614	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	36,076	0		19,330	3.00
4.00 SUBPROVIDER I						4.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
200.00 Total	0	-157,203	-76,889	0	-379,284	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: 15-0011		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/25/2019 10:38 am				
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 441 WABASH AVENUE			PO Box:						1.00
2.00	City: MARION			State: IN		Zip Code: 46952-		County: GRANT		2.00
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	MARION GENERAL HOSPITAL	150011	99915	1	07/01/1966	N	P	0	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	MARION GENERAL HOSPITAL	15T011	99915	5	07/01/2005	N	P	0	5.00
6.00	Subprovider - (Other)	REHAB								6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:		To:		
						1.00		2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2018		06/30/2019		20.00
21.00	Type of Control (see instructions)					2				21.00
						1.00	2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				Y	N				22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				N	Y				22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N	N				22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				N	N		N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.				3	N				23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid 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.	707	1,258	0	0	3,121	0			24.00

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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.	174	0	0	0	68		25.00	
						Urban/Rural	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.					1		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.					07/01/2018	06/30/2019	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)					Y	Y	40.00	
						V	XVII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
						NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
						1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)					N			60.00

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

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

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		1.00	2.00	3.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00
		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	Y		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	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

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		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			109.00
					1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N			110.00
					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	
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		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.				Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.				Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.				1			118.00
		Premiums		Losses		Insurance		
		1.00		2.00		3.00		
118.01	List amounts of malpractice premiums and paid losses:	1,333,414		0		0		118.01
				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
DO NOT USE THIS LINE								
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		119.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.				N			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.				N			122.00
Transplant Center Information								
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.				N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							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								

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0011		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/25/2019 10:38 am	
		1.00		2.00			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00	
		1.00		2.00		3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
						1.00	
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.					145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		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	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC			N		N	
						1.00	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	
		Name		County		State	
		0		1.00		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	
						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	
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)					0	
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	
						1.00	
						Beginni ng	
						Endi ng	
						1.00	
						2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2015		09/30/2015		170.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part I Date/Time Prepared: 11/25/2019 10:38 am	
		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. 1, 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		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 11/25/2019 10:38 am	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	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)	Y	09/23/2019	Y	09/23/2019
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 11/25/2019 10:38 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				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.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				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.				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				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				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.				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.				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.				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.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				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.				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.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				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.	TINA		SEVERS	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946		TSEVERS@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet S-2
Part II
Date/Time Prepared:
11/25/2019 10:38 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet S-3
Part I
Date/Time Prepared:
11/25/2019 10:38 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					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	87	31,755	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		87	31,755	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	19	6,935	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY					0	13.00
14.00 Total (see instructions)		106	38,690	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00 SUBPROVIDER - IRF	41.00	18	6,570		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	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)		124				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet S-3
Part I
Date/Time Prepared:
11/25/2019 10:38 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	5,955	707	13,514			1.00
2.00 HMO and other (see instructions)	3,438	4,379				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	406	68				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	5,955	707	13,514			7.00
8.00 INTENSIVE CARE UNIT	1,175	0	3,749			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		0	1,910			13.00
14.00 Total (see instructions)	7,130	707	19,173	0.00	695.21	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00 SUBPROVIDER - IRF	2,091	174	2,821	0.00	15.69	17.00
18.00 SUBPROVIDER		0	0	0.00	0.00	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)			66			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	710.90	27.00
28.00 Observation Bed Days		1,019	3,393			28.00
29.00 Ambulance Trips	1,349					29.00
30.00 Employee discount days (see instruction)			140			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: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet S-3
Part I
Date/Time Prepared:
11/25/2019 10:38 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	1,856	118	4,850	1.00
2.00 HMO and other (see instructions)				790	1,037		2.00
3.00 HMO IPF Subprovider					0		3.00
4.00 HMO IRF Subprovider					7		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0		1,856	118	4,850	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF	0.00	0		0	0	0	16.00
17.00 SUBPROVIDER - IRF	0.00	0		212	16	276	17.00
18.00 SUBPROVIDER	0.00	0			0	0	18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days				0			33.00
33.01 LTCH site neutral days and discharges				0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet S-3
Part II
Date/Time Prepared:
11/25/2019 10:38 am

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	46,401,926	19,581,892	65,983,818	2,048,780.00	32.21 1.00
2.00	Non-physician anesthesiologist Part A		0	0	0	0.00	0.00 2.00
3.00	Non-physician anesthesiologist Part B		0	0	0	0.00	0.00 3.00
4.00	Physician-Part A - Administrative		524,819	0	524,819	2,796.00	187.70 4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00 4.01
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00 5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00 6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00 7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00 7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00 8.00
9.00	SNF	44.00	0	0	0	0.00	0.00 9.00
10.00	Excluded area salaries (see instructions)		9,015,818	15,994,520	25,010,338	635,194.00	39.37 10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		7,957,013	0	7,957,013	226,064.00	35.20 11.00
12.00	Contract Labor: Top level management and other management and administrative services		0	0	0	0.00	0.00 12.00
13.00	Contract Labor: Physician-Part A - Administrative		227,888	0	227,888	1,285.00	177.34 13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00 14.00
14.01	Home office salaries		0	0	0	0.00	0.00 14.01
14.02	Related organization salaries		0	0	0	0.00	0.00 14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00 15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		13,721,295	0	13,721,295		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		7,301,330	0	7,301,330		
20.00	Non-physician anesthesiologist Part A		0	0	0		
21.00	Non-physician anesthesiologist Part B		0	0	0		
22.00	Physician Part A - Administrative		100,671	0	100,671		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet S-3
Part II
Date/Time Prepared:
11/25/2019 10:38 am

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	800,602	23,763	824,365	24,664.00	33.42	26.00
27.00	Administrative & General	5.00	7,712,906	221,541	7,934,447	336,019.00	23.61	27.00
28.00	Administrative & General under contract (see inst.)		1,827,352	0	1,827,352	13,835.00	132.08	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	663,677	0	663,677	34,684.00	19.13	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,254,425	0	1,254,425	104,011.00	12.06	33.00
34.00	Dietary	10.00	1,133	0	1,133	87.00	13.02	34.00
35.00	Dietary under contract (see instructions)		288,175	0	288,175	21,820.00	13.21	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,140,489	-272,982	867,507	22,075.00	39.30	38.00
39.00	Central Services and Supply	14.00	125,022	7,990	133,012	7,785.00	17.09	39.00
40.00	Pharmacy	15.00	2,736,855	-13,185	2,723,670	71,384.00	38.16	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet S-3
Part III
Date/Time Prepared:
11/25/2019 10:38 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Sal ari es (from Worksheet A-6)	Adjusted Sal ari es (col . 2 ± col . 3)	Pai d Hours Related to Sal ari es i n col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	49,771,878	19,581,892	69,353,770	2,188,446.00	31.69	1.00
2.00	Excluded area salaries (see instructions)	9,015,818	15,994,520	25,010,338	635,194.00	39.37	2.00
3.00	Subtotal salaries (line 1 minus line 2)	40,756,060	3,587,372	44,343,432	1,553,252.00	28.55	3.00
4.00	Subtotal other wages & related costs (see inst.)	8,184,901	0	8,184,901	227,349.00	36.00	4.00
5.00	Subtotal wage-related costs (see inst.)	13,821,966	0	13,821,966	0.00	31.17	5.00
6.00	Total (sum of lines 3 thru 5)	62,762,927	3,587,372	66,350,299	1,780,601.00	37.26	6.00
7.00	Total overhead cost (see instructions)	16,550,636	-32,873	16,517,763	636,364.00	25.96	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet S-3 Part IV Date/Time Prepared: 11/25/2019 10:38 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			1,252,814 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			3,570,571 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0 4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			1,443,266 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			0 8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)			0 8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)			9,656,005 8.02
8.03	Health Insurance (Purchased)			0 8.03
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			0 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			0 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			0 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			365,693 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			279,734 15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)			0 16.00
TAXES				
17.00	FICA-Employers Portion Only			4,271,131 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			13,816 19.00
20.00	State or Federal Unemployment Taxes			0 20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			0 21.00
22.00	Day Care Cost and Allowances			0 22.00
23.00	Tuition Reimbursement			270,267 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			21,123,297 24.00
Part B - Other than Core Related Cost				
25.00	OTHER			0 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet S-3 Part V Date/Time Prepared: 11/25/2019 10:38 am
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	7,957,013	21,123,297	1.00
2.00	Hospital	7,957,013	21,123,297	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet S-10 Date/Time Prepared: 11/25/2019 10:38 am
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			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)		0.248195	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		21,453,016	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		86,659,231	6.00	
7.00	Medicaid cost (line 1 times line 6)		21,508,388	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)		55,372	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		0	9.00	
10.00	Stand-alone CHIP charges		0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		55,372	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)	11,547,136	5,925,255	17,472,391	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,865,941	5,925,255	8,791,196	21.00
22.00	Payments received from patients for amounts previously written off as charity care	408	1,816	2,224	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,865,533	5,923,439	8,788,972	23.00
			1.00		
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		10,388,373		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		624,062		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		960,095		27.01
28.00	Non-Medicare bad debt expense (see instructions)		9,428,278		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		2,676,084		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		11,465,056		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		11,520,428		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet A

Date/Time Prepared:
11/25/2019 10:38 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (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	NEW CAP REL COSTS-BLDG & FIXT		13,395,795		13,395,795	-997,046	12,398,749	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	800,602	20,845,350		21,645,952	54,580	21,700,532	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,712,906	27,465,350		35,178,256	221,322	35,399,578	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0		0	0	0	6.00
6.01	00601	CAFETERIA	0	0		0	1,364,623	1,364,623	6.01
6.02	00602	CAFETERIA	0	0		0	0	0	6.02
7.00	00700	OPERATION OF PLANT	663,677	4,558,710		5,222,387	385,562	5,607,949	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0		0	388,048	388,048	8.00
9.00	00900	HOUSEKEEPING	0	2,908,852		2,908,852	-379,391	2,529,461	9.00
10.00	01000	DIETARY	1,133	1,946,552		1,947,685	-1,392,590	555,095	10.00
13.00	01300	NURSING ADMINISTRATION	1,140,489	81,353		1,221,842	-272,982	948,860	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	125,022	287,580		412,602	7,990	420,592	14.00
15.00	01500	PHARMACY	2,736,855	8,943,251		11,680,106	-8,081,692	3,598,414	15.00
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	7,077,293	1,632,244		8,709,537	-936,541	7,772,996	30.00
31.00	03100	INTENSIVE CARE UNIT	1,993,914	658,020		2,651,934	-23,763	2,628,171	31.00
40.00	04000	SUBPROVIDER - IPF	0	0		0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	989,097	813,021		1,802,118	0	1,802,118	41.00
42.00	04200	SUBPROVIDER	0	0		0	0	0	42.00
43.00	04300	NURSERY	0	0		0	1,116,333	1,116,333	43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	13,083,275		13,083,275	146,048	13,229,323	50.00
51.00	05100	RECOVERY ROOM	0	0		0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,093,043	3,176,485		6,269,528	-1,161,276	5,108,252	54.00
57.00	05700	CT SCAN	0	0		0	1,066,736	1,066,736	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	546,599	546,599	58.00
59.00	05900	CARDIAC CATHETERIZATION	599,630	1,203,516		1,803,146	23,729	1,826,875	59.00
60.00	06000	LABORATORY	2,261,493	5,770,617		8,032,110	-21,918	8,010,192	60.00
60.01	06001	ONCOLOGY	1,013,129	617,730		1,630,859	0	1,630,859	60.01
60.02	06002	RADIATION ONCOLOGY	0	0		0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	1,242,250	910,149		2,152,399	1,618	2,154,017	65.00
66.00	06600	PHYSICAL THERAPY	1,798,496	256,418		2,054,914	0	2,054,914	66.00
69.00	06900	ELECTROCARDIOLOGY	793,504	164,114		957,618	64,774	1,022,392	69.00
69.01	06901	CARDIAC REHAB	145,504	5,038		150,542	36,191	186,733	69.01
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	8,081,692	8,081,692	73.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	273,595	518,911		792,506	27,231	819,737	90.00
91.00	09100	EMERGENCY	3,913,573	4,936,990		8,850,563	-47,051	8,803,512	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	1,023,608	169,771		1,193,379	20,911	1,214,290	95.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE	0	0		0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	39,398,813	114,349,092		153,747,905	239,737	153,987,642	118.00
NONREIMBURSABLE COST CENTERS									
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,560		15,560	28,592	44,152	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		0	0	0	192.00
192.02	19202	VISITOR MEALS	0	0		0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	91,124	4,673		95,797	8,503	104,300	192.03
192.04	19204	LIFELINE	0	0		0	0	0	192.04
192.05	19205	OWNED PROPERTIES	0	1,298,974		1,298,974	-1,071,607	227,367	192.05
192.06	19206	UROLOGY	339,304	1,013,201		1,352,505	44,029	1,396,534	192.06
192.08	19211	PARI SH NURSING	27,240	16,675		43,915	6,952	50,867	192.08
192.09	19212	BIOTERRORISM GRANT	0	0		0	0	0	192.09
192.10	19214	BREAST PUMPS	0	0		0	0	0	192.10
192.11	19208	MGH EMERGENCY PHYSICIANS	0	0		0	0	0	192.11
192.12	19209	LUNG CENTER	126,687	675,595		802,282	24,449	826,731	192.12
192.13	19213	MGH EXPRESS	346,017	479,662		825,679	33,583	859,262	192.13
192.14	19210	MGH PHYS PRACT MGMT	963,711	778,748		1,742,459	36,639	1,779,098	192.14
192.15	19215	MGH MARION SURGEONS	440,875	1,522,555		1,963,430	62,257	2,025,687	192.15
192.16	19216	MGH MGH MED ONC	0	1,394,165		1,394,165	0	1,394,165	192.16
192.17	19217	MGH FMC SOUTH	782,973	2,503,699		3,286,672	1,681	3,288,353	192.17
192.18	19218	MGH FAIRM MED ASSOC	112,161	241,923		354,084	41,416	395,500	192.18
192.19	19219	MGH FMC MARION	273,059	541,833		814,892	32,862	847,754	192.19
193.00	19300	NONPAID WORKERS	0	0		0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	341,450	955,641		1,297,091	0	1,297,091	193.01
193.02	19302	MGH FMC GAS CITY	237,906	650,948		888,854	73,517	962,371	193.02
193.03	19303	MGH HOSPITALISTS	-8,943	4,350,090		4,341,147	0	4,341,147	193.03

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet A

Date/Time Prepared:
11/25/2019 10:38 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
193.04	19304 MGH MAR FAM PRACT	969,146	2,120,897	3,090,043	0	3,090,043	193.04
193.05	19305 MGH FMC SWAYZEE	80,062	169,162	249,224	24,851	274,075	193.05
193.06	19306 MGH PEDIATRIC CTR	233,362	795,304	1,028,666	49,808	1,078,474	193.06
193.07	19307 MGH SPECIALTY PHYS	64,769	242,527	307,296	12,157	319,453	193.07
193.08	19308 MGH FMC CONVERSE	103,809	221,682	325,491	307	325,798	193.08
193.09	19309 MGH UPLAND HEALTH	477,930	1,289,721	1,767,651	5,474	1,773,125	193.09
193.10	19310 MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311 MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12	19312 OB/GYN	558,414	2,316,327	2,874,741	10,279	2,885,020	193.12
193.15	19315 MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
193.16	19316 MGH NEONATOLOGY	0	656,500	656,500	0	656,500	193.16
193.18	19318 MGH WOUND CARE	0	22,067	22,067	0	22,067	193.18
194.00	07963 HEART FAI LURE CLINIC	0	53,741	53,741	0	53,741	194.00
194.01	07950 MOW	0	0	0	0	0	194.01
194.02	07951 MENTAL HEALTH	0	0	0	0	0	194.02
194.03	07952 ADVERTISING	0	0	0	285,794	285,794	194.03
194.04	07953 MGH WORK SOLUTIONS	333,841	569,670	903,511	45,056	948,567	194.04
194.05	07954 MGH TAYLOR UNIVERSITY	21,279	139,582	160,861	0	160,861	194.05
194.08	07957 MGH SMMP BLDG	0	0	0	0	0	194.08
194.09	07958 MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959 MGH 106 LYONS BLDG	0	6,498	6,498	0	6,498	194.10
194.11	07960 FAIRMOUNT	0	0	0	0	0	194.11
194.12	07961 GAS CITY	0	0	0	0	0	194.12
194.13	07969 LYONS	0	0	0	0	0	194.13
194.14	07964 WABASH	0	0	0	0	0	194.14
194.15	07965 TOBACCO GRANT	49,592	13,641	63,233	3,664	66,897	194.15
194.16	07966 HRSA NETWORK DEV PLANNING	26,246	57,403	83,649	0	83,649	194.16
194.17	07967 HRSA OPIOID PLANNING	11,099	76,936	88,035	0	88,035	194.17
200.00	TOTAL (SUM OF LINES 118 through 199)	46,401,926	139,544,692	185,946,618	0	185,946,618	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet A
Date/Time Prepared:
11/25/2019 10:38 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-17,215	12,381,534	1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-3,079,955	18,620,577	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-16,084,168	19,315,410	5.00
6.00	00600 MAINTENANCE & REPAIRS	0	0	6.00
6.01	00601 CAFETERIA	-11,052	1,353,571	6.01
6.02	00602 CAFETERIA	0	0	6.02
7.00	00700 OPERATION OF PLANT	-188,525	5,419,424	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	-3,579	384,469	8.00
9.00	00900 HOUSEKEEPING	870	2,530,331	9.00
10.00	01000 DIETARY	20	555,115	10.00
13.00	01300 NURSING ADMINISTRATION	-25	948,835	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	-896	419,696	14.00
15.00	01500 PHARMACY	-20,105	3,578,309	15.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-29,660	7,743,336	30.00
31.00	03100 INTENSIVE CARE UNIT	-878	2,627,293	31.00
40.00	04000 SUBPROVIDER - I PF	0	0	40.00
41.00	04100 SUBPROVIDER - I RF	-83,879	1,718,239	41.00
42.00	04200 SUBPROVIDER	0	0	42.00
43.00	04300 NURSERY	0	1,116,333	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-1,355,446	11,873,877	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	-209,159	4,899,093	54.00
57.00	05700 CT SCAN	0	1,066,736	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	546,599	58.00
59.00	05900 CARDIAC CATHETERIZATION	-66,396	1,760,479	59.00
60.00	06000 LABORATORY	-121,496	7,888,696	60.00
60.01	06001 ONCOLOGY	-5,202	1,625,657	60.01
60.02	06002 RADIATION ONCOLOGY	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	-547	2,153,470	65.00
66.00	06600 PHYSICAL THERAPY	-148	2,054,766	66.00
69.00	06900 ELECTROCARDIOLOGY	-53,983	968,409	69.00
69.01	06901 CARDIAC REHAB	-11	186,722	69.01
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	8,081,692	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	-1,020	818,717	90.00
91.00	09100 EMERGENCY	-3,411,681	5,391,831	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	92.01
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	-65,089	1,149,201	95.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-24,809,225	129,178,417	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	44,152	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.02	19202 VISITOR MEALS	0	0	192.02
192.03	19203 GREAT BEGINNINGS/MATERNAL	0	104,300	192.03
192.04	19204 LI FELINE	-109,424	-109,424	192.04
192.05	19205 OWNED PROPERTIES	0	227,367	192.05
192.06	19206 UROLOGY	-59,053	1,337,481	192.06
192.08	19211 PARI SH NURSING	0	50,867	192.08
192.09	19212 BIOTERRORISM GRANT	0	0	192.09
192.10	19214 BREAST PUMPS	0	0	192.10
192.11	19208 MGH EMERGENCY PHYSICIANS	0	0	192.11
192.12	19209 LUNG CENTER	-48,229	778,502	192.12
192.13	19213 MGH EXPRESS	0	859,262	192.13
192.14	19210 MGH PHYS PRACT MGMT	-67,944	1,711,154	192.14
192.15	19215 MGH MARION SURGEONS	-112,963	1,912,724	192.15
192.16	19216 MGH MGH MED ONC	0	1,394,165	192.16
192.17	19217 MGH FMC SOUTH	-338,868	2,949,485	192.17
192.18	19218 MGH FAIRM MED ASSOC	-27,088	368,412	192.18
192.19	19219 MGH FMC MARION	-61,469	786,285	192.19
193.00	19300 NONPAID WORKERS	0	0	193.00
193.01	19301 MGH FMC NORTHWOOD	0	1,297,091	193.01
193.02	19302 MGH FMC GAS CITY	-144,701	817,670	193.02
193.03	19303 MGH HOSPITALISTS	0	4,341,147	193.03
193.04	19304 MGH MAR FAM PRACT	0	3,090,043	193.04

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet A
Date/Time Prepared:
11/25/2019 10:38 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
193.05	19305	MGH FMC SWAYZEE	-27,472	246,603	193.05
193.06	19306	MGH PEDIATRIC CTR	-66,454	1,012,020	193.06
193.07	19307	MGH SPECIALTY PHYS	-24,861	294,592	193.07
193.08	19308	MGH FMC CONVERSE	0	325,798	193.08
193.09	19309	MGH UPLAND HEALTH	0	1,773,125	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	193.11
193.12	19312	OB/GYN	0	2,885,020	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	193.15
193.16	19316	MGH NEONATOLOGY	0	656,500	193.16
193.18	19318	MGH WOUND CARE	0	22,067	193.18
194.00	07963	HEART FAI LURE CLINI C	0	53,741	194.00
194.01	07950	MOW	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	194.02
194.03	07952	ADVERTI SING	0	285,794	194.03
194.04	07953	MGH WORK SOLUTI ONS	0	948,567	194.04
194.05	07954	MGH TAYLOR UNI VERSI TY	0	160,861	194.05
194.08	07957	MGH SMMP BLDG	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	6,498	194.10
194.11	07960	FAI RMOUNT	0	0	194.11
194.12	07961	GAS CI TY	0	0	194.12
194.13	07969	LYONS	0	0	194.13
194.14	07964	WABASH	0	0	194.14
194.15	07965	TOBACCO GRANT	0	66,897	194.15
194.16	07966	HRSA NETWORK DEV PLANNI NG	0	83,649	194.16
194.17	07967	HRSA OPI OI D PLANNI NG	0	88,035	194.17
200.00		TOTAL (SUM OF LI NES 118 through 199)	-25,897,751	160,048,867	200.00

RECLASSIFICATIONS

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-6
Date/Time Prepared:
11/25/2019 10:38 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - SATELLITE OFFICE RECLASS						
1.00	ELECTROCARDIOLOGY	69.00	11,615	3,751	1.00	
2.00	RADIOLOGY-DIAGNOSTIC	54.00	74,242	7,452	2.00	
	TOTALS		85,857	11,203		
B - CAFETERIA RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	53,432	1.00	
2.00	CAFETERIA	6.01	0	1,364,623	2.00	
	TOTALS		0	1,418,055		
C - ADMIN DIRECTOR RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	23,763	0	1.00	
2.00	CENTRAL SERVICES & SUPPLY	14.00	7,990	0	2.00	
3.00	ADULTS & PEDIATRICS	30.00	179,792	0	3.00	
4.00	CARDIAC CATHETERIZATION	59.00	23,729	0	4.00	
5.00	RESPIRATORY THERAPY	65.00	1,618	0	5.00	
6.00	ELECTROCARDIOLOGY	69.00	35,610	0	6.00	
7.00	CARDIAC REHAB	69.01	23,729	0	7.00	
8.00	AMBULANCE SERVICES	95.00	20,911	0	8.00	
9.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	28,592	0	9.00	
10.00	GREAT BEGINNINGS/MATERNAL	192.03	8,503	0	10.00	
11.00	PARI SH NURSING	192.08	3,664	0	11.00	
12.00	MGH EXPRESS	192.13	26,139	0	12.00	
13.00	TOBACCO GRANT	194.15	3,664	0	13.00	
	TOTALS		387,704	0		
D - ADVERTISING						
1.00	ADVERTISING	194.03	171,534	114,260	1.00	
	TOTALS		171,534	114,260		
E - LEASED PROPERTY						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	30,817	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	0	112,973	2.00	
3.00	OPERATION OF PLANT	7.00	0	384,054	3.00	
4.00	HOUSEKEEPING	9.00	0	8,325	4.00	
5.00	DIETARY	10.00	0	24,906	5.00	
6.00	OPERATING ROOM	50.00	0	146,048	6.00	
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	301,056	7.00	
8.00	CT SCAN	57.00	0	21,411	8.00	
9.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	24,145	9.00	
10.00	LABORATORY	60.00	0	72,542	10.00	
11.00	ELECTROCARDIOLOGY	69.00	0	13,798	11.00	
12.00	CARDIAC REHAB	69.01	0	12,462	12.00	
13.00	CLINIC	90.00	0	27,231	13.00	
14.00	PARI SH NURSING	192.08	0	3,288	14.00	
15.00	LUNG CENTER	192.12	0	24,449	15.00	
16.00	MGH EXPRESS	192.13	0	7,444	16.00	
17.00	MGH PHYS PRACT MGMT	192.14	0	36,639	17.00	
18.00	MGH MARION SURGEONS	192.15	0	62,257	18.00	
19.00	MGH FMC SOUTH	192.17	0	348,492	19.00	
20.00	MGH FAIRM MED ASSOC	192.18	0	41,416	20.00	
21.00	MGH FMC MARION	192.19	0	32,862	21.00	
22.00	MGH WORK SOLUTIONS	194.04	0	45,056	22.00	
23.00	UROLOGY	192.06	0	44,029	23.00	
24.00	MGH FMC GAS CITY	193.02	0	73,517	24.00	
25.00	MGH FMC SWAYZEE	193.05	0	24,851	25.00	
26.00	MGH PEDIATRIC CTR	193.06	0	49,808	26.00	
27.00	MGH SPECIALTY PHYS	193.07	0	12,157	27.00	
28.00	MGH FMC CONVERSE	193.08	0	307	28.00	
29.00	MGH UPLAND HEALTH	193.09	0	5,474	29.00	
30.00	OB/GYN	193.12	0	10,279	30.00	
	TOTALS		0	2,002,093		
F - PHARMACY RECLASS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	8,081,692	1.00	
	TOTALS		0	8,081,692		
G - CT/MRI RECLASS						
1.00	CT SCAN	57.00	514,994	528,887	1.00	
2.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	256,948	263,880	2.00	
	TOTALS		771,942	792,767		
H - SHORT TERM DISABILITY						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	19,968	1.00	
2.00	PHARMACY	15.00	0	13,185	2.00	
3.00	ADULTS & PEDIATRICS	30.00	0	3,317	3.00	
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,344	4.00	
5.00	CARDIAC CATHETERIZATION	59.00	0	5,395	5.00	

RECLASSIFICATIONS

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-6

Date/Time Prepared:
11/25/2019 10:38 am

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
6.00	LABORATORY	60.00	0	1,269	6.00
7.00	RESPIRATORY THERAPY	65.00	0	2,177	7.00
8.00	EMERGENCY	91.00	0	2,259	8.00
9.00	MGH PHYS PRACT MGMT	192.14	0	272	9.00
	TOTALS		0	49,186	
I - NURSERY RECLASS					
1.00	NURSERY	43.00	969,937	146,396	1.00
	TOTALS		969,937	146,396	
J - SMMP HOUSEKEEPING RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	14,618	1.00
2.00	OPERATION OF PLANT	7.00	0	1,508	2.00
3.00	HOUSEKEEPING	9.00	0	332	3.00
4.00	DIETARY	10.00	0	559	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	20,683	5.00
6.00	CT SCAN	57.00	0	1,444	6.00
7.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,626	7.00
8.00	LABORATORY	60.00	0	2,600	8.00
9.00	MGH FMC SOUTH	192.17	0	23,190	9.00
	TOTALS		0	66,560	
K - LAUNDRY RECLASS					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	388,048	1.00
	TOTALS		0	388,048	
L - PHYSICIAN MEDICAL DIRECTOR					
1.00	ADMINISTRATIVE & GENERAL	5.00	370,001	0	1.00
	TOTALS		370,001	0	
M - PHYSICIAN RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	86,950	0	1.00
2.00	SUBPROVIDER - IRF	41.00	82,070	0	2.00
3.00	RESPIRATORY THERAPY	65.00	6,738	0	3.00
4.00	PHYSICAL THERAPY	66.00	3,300	0	4.00
5.00	CARDIAC REHAB	69.01	0	3,600	5.00
6.00	CLINIC	90.00	0	216	6.00
7.00	EMERGENCY	91.00	3,436,120	0	7.00
8.00	UROLOGY	192.06	588,491	0	8.00
9.00	LUNG CENTER	192.12	252,271	0	9.00
10.00	MGH EXPRESS	192.13	610,808	0	10.00
11.00	MGH MARION SURGEONS	192.15	1,376,745	0	11.00
12.00	MGH MGH MED ONC	192.16	1,390,972	0	12.00
13.00	MGH FMC SOUTH	192.17	1,959,823	0	13.00
14.00	MGH FAIRM MED ASSOC	192.18	164,577	0	14.00
15.00	MGH FMC MARION	192.19	407,578	0	15.00
16.00	MGH FMC NORTHWOOD	193.01	801,044	0	16.00
17.00	MGH FMC GAS CITY	193.02	402,454	0	17.00
18.00	MGH HOSPITALISTS	193.03	2,489,758	0	18.00
19.00	MGH MAR FAM PRACT	193.04	1,573,392	0	19.00
20.00	MGH FMC SWAYZEE	193.05	107,537	0	20.00
21.00	MGH PEDIATRIC CTR	193.06	521,401	0	21.00
22.00	MGH SPECIALTY PHYS	193.07	204,381	0	22.00
23.00	MGH FMC CONVERSE	193.08	126,324	0	23.00
24.00	MGH UPLAND HEALTH	193.09	906,459	0	24.00
25.00	OB/GYN	193.12	1,634,245	0	25.00
26.00	MGH WOUND CARE	193.18	22,067	0	26.00
27.00	HEART FAILURE CLINIC	194.00	38,741	0	27.00
28.00	MGH WORK SOLUTIONS	194.04	310,423	0	28.00
29.00	MGH TAYLOR UNIVERSITY	194.05	130,225	0	29.00
	TOTALS		19,634,894	3,816	
500.00	Grand Total: Increases		22,391,869	13,074,076	500.00

RECLASSIFICATIONS

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-6
Date/Time Prepared:
11/25/2019 10:38 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - SATELLITE OFFICE RECLASS							
1.00	LABORATORY	60.00	11,615	3,751	0		1.00
2.00	LABORATORY	60.00	74,242	7,452	0		2.00
	TOTALS		85,857	11,203			
B - CAFETERIA RECLASS							
1.00	DIETARY	10.00	0	1,418,055	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	1,418,055			
C - ADMIN DIRECTOR RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	43,908	0	0		1.00
2.00	NURSING ADMINISTRATION	13.00	272,982	0	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	23,763	0	0		3.00
4.00	EMERGENCY	91.00	47,051	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
	TOTALS		387,704	0			
D - ADVERTISING							
1.00	ADMINISTRATIVE & GENERAL	5.00	171,534	114,260	0		1.00
	TOTALS		171,534	114,260			
E - LEASED PROPERTY							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	997,046	10		1.00
2.00	OWNED PROPERTIES	192.05	0	1,005,047	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
28.00		0.00	0	0	0		28.00
29.00		0.00	0	0	0		29.00
30.00		0.00	0	0	0		30.00
	TOTALS		0	2,002,093			
F - PHARMACY RECLASS							
1.00	PHARMACY	15.00	0	8,081,692	0		1.00
	TOTALS		0	8,081,692			
G - CT/MRI RECLASS							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	771,942	792,767	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		771,942	792,767			
H - SHORT TERM DISABILITY							
1.00	ADMINISTRATIVE & GENERAL	5.00	19,968	0	0		1.00
2.00	PHARMACY	15.00	13,185	0	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	3,317	0	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	1,344	0	0		4.00
5.00	CARDIAC CATHETERIZATION	59.00	5,395	0	0		5.00
6.00	LABORATORY	60.00	1,269	0	0		6.00
7.00	RESPIRATORY THERAPY	65.00	2,177	0	0		7.00

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
8.00	EMERGENCY	91.00	2,259	0	0		8.00
9.00	MGH PHYS PRACT MGMT	192.14	272	0	0		9.00
	TOTALS		49,186	0			
I - NURSERY RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	969,937	146,396	0		1.00
	TOTALS		969,937	146,396			
J - SMMP HOUSEKEEPING RECLASS							
1.00	OWNED PROPERTIES	192.05	0	66,560	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
	TOTALS		0	66,560			
K - LAUNDRY RECLASS							
1.00	HOUSEKEEPING	9.00	0	388,048	0		1.00
	TOTALS		0	388,048			
L - PHYSICIAN MEDICAL DIRECTOR							
1.00	MGH FMC SOUTH	192.17	370,001	0	0		1.00
	TOTALS		370,001	0			
M - PHYSICIAN RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	86,950	0		1.00
2.00	SUBPROVIDER - IRF	41.00	0	82,070	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	6,738	0		3.00
4.00	PHYSICAL THERAPY	66.00	0	3,300	0		4.00
5.00	CARDIAC REHAB	69.01	3,600	0	0		5.00
6.00	CLINIC	90.00	216	0	0		6.00
7.00	EMERGENCY	91.00	0	3,436,120	0		7.00
8.00	UROLOGY	192.06	0	588,491	0		8.00
9.00	LUNG CENTER	192.12	0	252,271	0		9.00
10.00	MGH EXPRESS	192.13	0	610,808	0		10.00
11.00	MGH MARION SURGEONS	192.15	0	1,376,745	0		11.00
12.00	MGH MGH MED ONC	192.16	0	1,390,972	0		12.00
13.00	MGH FMC SOUTH	192.17	0	1,959,823	0		13.00
14.00	MGH FAIRM MED ASSOC	192.18	0	164,577	0		14.00
15.00	MGH FMC MARION	192.19	0	407,578	0		15.00
16.00	MGH FMC NORTHWOOD	193.01	0	801,044	0		16.00
17.00	MGH FMC GAS CITY	193.02	0	402,454	0		17.00
18.00	MGH HOSPITALISTS	193.03	0	2,489,758	0		18.00
19.00	MGH MAR FAM PRACT	193.04	0	1,573,392	0		19.00
20.00	MGH FMC SWAYZEE	193.05	0	107,537	0		20.00
21.00	MGH PEDIATRIC CTR	193.06	0	521,401	0		21.00
22.00	MGH SPECIALTY PHYS	193.07	0	204,381	0		22.00
23.00	MGH FMC CONVERSE	193.08	0	126,324	0		23.00
24.00	MGH UPLAND HEALTH	193.09	0	906,459	0		24.00
25.00	OB/GYN	193.12	0	1,634,245	0		25.00
26.00	MGH WOUND CARE	193.18	0	22,067	0		26.00
27.00	HEART FAILURE CLINIC	194.00	0	38,741	0		27.00
28.00	MGH WORK SOLUTIONS	194.04	0	310,423	0		28.00
29.00	MGH TAYLOR UNIVERSITY	194.05	0	130,225	0		29.00
	TOTALS		3,816	19,634,894			
500.00	Grand Total: Decreases		2,809,977	32,655,968			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-7
Part I
Date/Time Prepared:
11/25/2019 10:38 am

		Acquisitions			Disposals and Retirements		
		Beginning Balances	Purchases	Donation			Total
		1.00	2.00	3.00			4.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	4,646,549	0	545,281	545,281	0	1.00
2.00	Land Improvements	3,353,531	0	0	0	0	2.00
3.00	Buildings and Fixtures	132,355,721	7,303,916	0	7,303,916	7,006	3.00
4.00	Building Improvements	3,287,381	263,831	0	263,831	0	4.00
5.00	Fixed Equipment	3,176,435	333,095	0	333,095	0	5.00
6.00	Movable Equipment	76,530,724	2,292,145	0	2,292,145	6,085,182	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	223,350,341	10,192,987	545,281	10,738,268	6,092,188	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	223,350,341	10,192,987	545,281	10,738,268	6,092,188	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	5,191,830	0				1.00
2.00	Land Improvements	3,353,531	0				2.00
3.00	Buildings and Fixtures	139,652,631	0				3.00
4.00	Building Improvements	3,551,212	0				4.00
5.00	Fixed Equipment	3,509,530	0				5.00
6.00	Movable Equipment	72,737,687	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	227,996,421	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	227,996,421	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-7
Part II
Date/Time Prepared:
11/25/2019 10:38 am

Cost Center Description	SUMMARY OF CAPITAL					
	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	13,395,795	0	0	0	0	1.00
3.00	Total (sum of lines 1-2)	13,395,795	0	0	0	0	3.00

Cost Center Description	SUMMARY OF CAPITAL		
	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
	14.00	15.00	

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	13,395,795	1.00
3.00	Total (sum of lines 1-2)	0	13,395,795	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-7
Part III
Date/Time Prepared:
11/25/2019 10:38 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	223,350,342	0	223,350,342	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	223,350,342	0	223,350,342	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	13,395,795	-997,046	1.00
3.00	Total (sum of lines 1-2)	0	0	0	13,395,795	-997,046	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	NEW CAP REL COSTS-BLDG & FIXT	-17,215	0	0	0	12,381,534	1.00
3.00	Total (sum of lines 1-2)	-17,215	0	0	0	12,381,534	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-8

Date/Time Prepared:
11/25/2019 10:38 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	*** Cost Center Deleted ***	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0			0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0			0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0			0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0			0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0			0	7.00
8.00 Television and radio service (chapter 21)			0			0	8.00
9.00 Parking lot (chapter 21)			0			0	9.00
10.00 Provider-based physician adjustment	A-8-2	-5,000,946				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0			0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1		0			0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-6,824	0	CAFETERIA	6.01	0	14.00
15.00 Rental of quarters to employees 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			0		0.00	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 - NEW CAP REL COSTS-BLDG & FIXT			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	*** Cost Center Deleted ***	2.00	0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-8

Date/Time Prepared:
11/25/2019 10:38 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00
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	ADMINISTRATIVE & GENERAL	5.00		32.00
33.00 ED ANESTHESIOLOGIST	A	-118,303	ADMINISTRATIVE & GENERAL	5.00		33.00
33.01 FINANCE BANK SERVICE CHARGES	A	-177,806	ADMINISTRATIVE & GENERAL	5.00		33.01
33.02 FINANCE DISCOUNT PAYMENTS	A	7,538	ADMINISTRATIVE & GENERAL	5.00		33.02
33.03 GAIN ON DISPOSAL	A	-9,929	ADMINISTRATIVE & GENERAL	5.00		33.03
33.04 XIX ASSESSMENT FEE A/C 7200.7892	A	-11,709,760	ADMINISTRATIVE & GENERAL	5.00		33.04
33.05 SELF INSURANCE EXPENSE	A	-3,079,935	EMPLOYEE BENEFITS DEPARTMENT	4.00		33.05
33.06 RETURNED CHECK FEE	B	-60	ADMINISTRATIVE & GENERAL	5.00		33.06
33.07 PHYSICIAN PRIV APPLIC	B	-7,600	ADMINISTRATIVE & GENERAL	5.00		33.07
33.08 SALE OF MEDICAL RECORDS & ABSTRACTS	B	-41,109	ADMINISTRATIVE & GENERAL	5.00		33.08
33.09 CHILD SEAT SAFETY INSPECTION	B	-726	ADMINISTRATIVE & GENERAL	5.00		33.09
33.10 HEALTH SCREENING FEES - LAB	B	-25,099	LABORATORY	60.00		33.10
33.11 HEALTH SCREENING FEES - RAD	B	-15,755	RADIOLOGY-DIAGNOSTIC	54.00		33.11
33.12 MED STAFF OTHER SCREENING-MED STAFF	B	924	ADMINISTRATIVE & GENERAL	5.00		33.12
33.13 FLU SHOT HEALTH SCREENS	B	-20	ADMINISTRATIVE & GENERAL	5.00		33.13
33.14 HEALTH SCREENS	B	-92	LABORATORY	60.00		33.14
33.15 HEALTH SCREENS	B	-4,851	LABORATORY	60.00		33.15
33.16 HEALTH SCREENS	B	390	LABORATORY	60.00		33.16
33.17 REBATE	B	-40,784	ADMINISTRATIVE & GENERAL	5.00		33.17
33.18 REBATE	B	-82,545	ADMINISTRATIVE & GENERAL	5.00		33.18
33.19 RENTAL OF PROVIDER SPACE BY SUPPLIER	B	-1,200	ADMINISTRATIVE & GENERAL	5.00		33.19
33.20 RENT SPACE UPLAND	B	-19,058	LABORATORY	60.00		33.20
33.21 PAGER RENTAL	B	-840	ADMINISTRATIVE & GENERAL	5.00		33.21
33.22 SALE OF SCRAP, WASTE, ETC,	B	-1,073	ADMINISTRATIVE & GENERAL	5.00		33.22
33.23 SALE OF UNI FORMS	B	-829	ADULTS & PEDIATRICS	30.00		33.23
33.24 PCC MARKETING AG	B	0	ADMINISTRATIVE & GENERAL	5.00		33.24
33.25 EDUCATIONAL WORKSHOP	B	-770	ADMINISTRATIVE & GENERAL	5.00		33.25
33.26 OPT HEALTH LINEN SEV	B	-3,579	LAUNDRY & LINEN SERVICE	8.00		33.26
33.27 AMBULANCE SVC - ASSISTS	B	-57,375	AMBULANCE SERVICES	95.00		33.27
33.28 AMBULANCE SVC - CORONER SVC	B	-248	AMBULANCE SERVICES	95.00		33.28
33.29 AMBULANCE SVC - LINEN SERVICES	B	-4,224	AMBULANCE SERVICES	95.00		33.29
33.30 AMBULANCE SVC - COMMUNITY EVENT STAF	B	-2,848	AMBULANCE SERVICES	95.00		33.30
33.31 CONTRACT ARU OTH ARU MEDICAL DIRECTO	B	-61,914	SUBPROVIDER - I RF	41.00		33.31
33.32 SCHOOL PHYS OTH SCHOOL PHYS	B	-3,000	ADMINISTRATIVE & GENERAL	5.00		33.32
33.33 PHLEBOTOMY	B	-6,000	LABORATORY	60.00		33.33
33.34 CPR TRAIN OTH AHA COMMUNITY	B	-12,748	ADMINISTRATIVE & GENERAL	5.00		33.34
33.35 CLINICAL STUDY- OTHER	B	-3,897	ONCOLOGY	60.01		33.35
33.36 SICK CHILD CARE PROGRAM	B	-1,235	ADULTS & PEDIATRICS	30.00		33.36
33.37 ONC. QUAL	B	-1,260	ADMINISTRATIVE & GENERAL	5.00		33.37
33.38 SETTLEMENTS	B	-1,268	ADMINISTRATIVE & GENERAL	5.00		33.38
33.39 UNCLAIMED OTHER 125 MED/CHILD CARE E	B	-9,961	ADMINISTRATIVE & GENERAL	5.00		33.39
33.40 UNCLAIMED OTHER MONIES RECOVERED	B	0	CAFETERIA	6.01		33.40
33.41 VENDING MACHINES	B	-4,228	CAFETERIA	6.01		33.41
33.42 MISC REV	B	-1,502	ADMINISTRATIVE & GENERAL	5.00		33.42
33.43 MISC REV	B	0	PHARMACY	15.00		33.43
33.44 TELEVISION AND RADIO SERVICE	A	-50,553	OPERATION OF PLANT	7.00		33.44
33.45 TELEPHONE SERVICE	A	-132,751	OPERATION OF PLANT	7.00		33.45
33.46 LOBBYING COSTS	A	-20,383	ADMINISTRATIVE & GENERAL	5.00		33.46
33.47 LOBBYING COSTS	A	-25	NURSING ADMINISTRATION	13.00		33.47
33.48 LOBBYING COSTS	A	-387	PHARMACY	15.00		33.48
33.49 LOBBYING COSTS	A	-531	ONCOLOGY	60.01		33.49
33.50 LOBBYING COSTS	A	0	RESPIRATORY THERAPY	65.00		33.50
33.51 LOBBYING COSTS	A	0	PHYSICAL THERAPY	66.00		33.51
33.52 ELIMINATING ENTRIES	A	-67,944	MGH PHYS PRACT MGMT	192.14		33.52

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-8

Date/Time Prepared:
11/25/2019 10:38 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.	
			Cost Center	Line #			
			1.00	2.00	3.00		
33.53 ELIMINATING ENTRIES	A	-109,424	LI FELINE	192.04		0	33.53
33.54 ELIMINATING ENTRIES	A	-48,229	LUNG CENTER	192.12		0	33.54
33.55 ELIMINATING ENTRIES	A	-112,963	MGH MARION SURGEONS	192.15		0	33.55
33.56 ELIMINATING ENTRIES	A	-338,868	MGH FMC SOUTH	192.17		0	33.56
33.57 ELIMINATING ENTRIES	A	-27,088	MGH FAIRM MED ASSOC	192.18		0	33.57
33.58 ELIMINATING ENTRIES	A	-61,469	MGH FMC MARION	192.19		0	33.58
33.59 ELIMINATING ENTRIES	A	-144,701	MGH FMC GAS CITY	193.02		0	33.59
33.60 ELIMINATING ENTRIES	A	-27,472	MGH FMC SWAYZEE	193.05		0	33.60
33.61 ELIMINATING ENTRIES	A	-66,454	MGH PEDIATRIC CTR	193.06		0	33.61
33.62 ELIMINATING ENTRIES	A	-59,053	UROLOGY	192.06		0	33.62
33.63 ELIMINATING ENTRIES	A	-24,861	MGH SPECIALTY PHYS	193.07		0	33.63
33.64 PHYSICIAN RECRUITMENT	A	-1,001,005	ADMINISTRATIVE & GENERAL	5.00		0	33.64
33.65 ENTERTAINMENT EXP	A	-698	ADMINISTRATIVE & GENERAL	5.00		0	33.65
33.66 EMPLOYEE USE OF AUTO	A	-3,066	ADMINISTRATIVE & GENERAL	5.00		0	33.66
33.67 DONATIONS	A	-171,374	ADMINISTRATIVE & GENERAL	5.00		0	33.67
33.68 VHA OPPORTUNITY	A	-20	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	33.68
33.69 VHA OPPORTUNITY	A	-10,331	ADMINISTRATIVE & GENERAL	5.00		0	33.69
33.70 VHA OPPORTUNITY	A	-5,221	OPERATION OF PLANT	7.00		0	33.70
33.71 VHA OPPORTUNITY	A	870	HOUSEKEEPING	9.00		0	33.71
33.72 VHA OPPORTUNITY	A	20	DIETARY	10.00		0	33.72
33.73 VHA OPPORTUNITY	A	-896	CENTRAL SERVICES & SUPPLY	14.00		0	33.73
33.74 VHA OPPORTUNITY	A	-19,718	PHARMACY	15.00		0	33.74
33.75 VHA OPPORTUNITY	A	-27,596	ADULTS & PEDIATRICS	30.00		0	33.75
33.76 VHA OPPORTUNITY	A	-878	INTENSIVE CARE UNIT	31.00		0	33.76
33.77 VHA OPPORTUNITY	A	-205	SUBPROVIDER - IRF	41.00		0	33.77
33.78 VHA OPPORTUNITY	A	-31,045	OPERATING ROOM	50.00		0	33.78
33.79 VHA OPPORTUNITY	A	-12,691	RADIOLOGY-DIAGNOSTIC	54.00		0	33.79
33.80 VHA OPPORTUNITY	A	-66,396	CARDIAC CATHETERIZATION	59.00		0	33.80
33.81 VHA OPPORTUNITY	A	-55,786	LABORATORY	60.00		0	33.81
33.82 VHA OPPORTUNITY	A	-774	ONCOLOGY	60.01		0	33.82
33.83 VHA OPPORTUNITY	A	-547	RESPIRATORY THERAPY	65.00		0	33.83
33.84 VHA OPPORTUNITY	A	-148	PHYSICAL THERAPY	66.00		0	33.84
33.85 VHA OPPORTUNITY	A	-328	ELECTROCARDIOLOGY	69.00		0	33.85
33.86 VHA OPPORTUNITY	A	-11	CARDIAC REHAB	69.01		0	33.86
33.87 VHA OPPORTUNITY	A	-1,020	CLINIC	90.00		0	33.87
33.88 VHA OPPORTUNITY	A	-2,264	EMERGENCY	91.00		0	33.88
33.89 VHA OPPORTUNITY	A	-394	AMBULANCE SERVICES	95.00		0	33.89
33.90 ED ON CALL SVC A/C 7000.2512	A	-2,661,509	ADMINISTRATIVE & GENERAL	5.00		0	33.90
33.91 OPERATING INTEREST INCOME	B	-17,215	NEW CAP REL COSTS-BLDG & FIXT	1.00		11	33.91
33.92 DEPOSITION-OTHER	B	-2,000	ADMINISTRATIVE & GENERAL	5.00		0	33.92
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-25,897,751					50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-8-2

Date/Time Prepared:
11/25/2019 10:38 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	41.00	SUBPROVIDER - IRF	21,760	21,760	0	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	53,655	53,655	0	0	0	2.00
3.00	50.00	OPERATING ROOM	1,324,401	1,324,401	0	0	0	3.00
4.00	91.00	EMERGENCY	3,409,417	3,409,417	0	0	0	4.00
5.00	60.00	LABORATORY	11,000	11,000	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	180,713	180,713	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		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			5,000,946	5,000,946	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		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	41.00	SUBPROVIDER - IRF	0	0	0	21,760		1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	53,655		2.00
3.00	50.00	OPERATING ROOM	0	0	0	1,324,401		3.00
4.00	91.00	EMERGENCY	0	0	0	3,409,417		4.00
5.00	60.00	LABORATORY	0	0	0	11,000		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	180,713		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		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	5,000,946		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet B
Part I
Date/Time Prepared:
11/25/2019 10:38 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	12,381,534	12,381,534				1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	18,620,577	467,893	19,088,470			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	19,315,410	2,027,894	2,324,407	23,667,711	23,667,711	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
6.01 00601	CAFETERIA	1,353,571	163,071	0	1,516,642	262,989	6.01
6.02 00602	CAFETERIA	0	0	0	0	0	6.02
7.00 00700	OPERATION OF PLANT	5,419,424	3,291,499	194,424	8,905,347	1,544,205	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	384,469	70,943	0	455,412	78,969	8.00
9.00 00900	HOUSEKEEPING	2,530,331	109,453	0	2,639,784	457,744	9.00
10.00 01000	DIETARY	555,115	224,680	332	780,127	135,276	10.00
13.00 01300	NURSING ADMINISTRATION	948,835	23,368	254,136	1,226,339	212,650	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	419,696	80,008	38,966	538,670	93,406	14.00
15.00 01500	PHARMACY	3,578,309	103,073	797,899	4,479,281	776,716	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	7,743,336	1,450,347	1,840,848	11,034,531	1,913,410	30.00
31.00 03100	INTENSIVE CARE UNIT	2,627,293	336,415	577,156	3,540,864	613,993	31.00
40.00 04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - IRF	1,718,239	321,811	313,798	2,353,848	408,162	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	1,116,333	0	284,143	1,400,476	242,845	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	11,873,877	1,156,739	0	13,030,616	2,259,505	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,899,093	694,520	701,322	6,294,935	1,091,554	54.00
57.00 05700	CT SCAN	1,066,736	50,529	150,867	1,268,132	219,897	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	546,599	59,897	75,273	681,769	118,220	58.00
59.00 05900	CARDIAC CATHETERIZATION	1,760,479	169,215	181,033	2,110,727	366,004	59.00
60.00 06000	LABORATORY	7,888,696	439,690	636,981	8,965,367	1,554,613	60.00
60.01 06001	ONCOLOGY	1,625,657	0	296,796	1,922,453	333,357	60.01
60.02 06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00 06500	RESPIRATORY THERAPY	2,153,470	149,574	365,727	2,668,771	462,770	65.00
66.00 06600	PHYSICAL THERAPY	2,054,766	29,579	527,836	2,612,181	452,957	66.00
69.00 06900	ELECTROCARDIOLOGY	968,409	267,051	246,292	1,481,752	256,939	69.00
69.01 06901	CARDIAC REHAB	186,722	43,546	48,522	278,790	48,343	69.01
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	8,081,692	0	0	8,081,692	1,401,382	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	818,717	95,083	80,086	993,886	172,342	90.00
91.00 09100	EMERGENCY	5,391,831	371,702	2,138,647	7,902,180	1,370,254	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01 09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	1,149,201	139,334	305,992	1,594,527	276,494	95.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	129,178,417	12,336,914	12,381,483	122,426,810	17,124,996	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GI FT, FLOWER, COFFEE SHOP & CANTEEN	44,152	44,620	8,376	97,148	16,846	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02 19202	VISITOR MEALS	0	0	0	0	0	192.02
192.03 19203	GREAT BEGINNINGS/MATERNAL	104,300	0	29,186	133,486	23,147	192.03
192.04 19204	LIFELINE	-109,424	0	0	-109,424	0	192.04
192.05 19205	OWNED PROPERTIES	227,367	0	0	227,367	39,426	192.05
192.06 19206	UROLOGY	1,337,481	0	271,798	1,609,279	279,052	192.06
192.08 19211	PARI SH NURSING	50,867	0	9,053	59,920	10,390	192.08
192.09 19212	BIOTERRORISM GRANT	0	0	0	0	0	192.09
192.10 19214	BREAST PUMPS	0	0	0	0	0	192.10
192.11 19208	MGH EMERGENCY PHYSICIANS	0	0	0	0	0	192.11
192.12 19209	LUNG CENTER	778,502	0	111,016	889,518	154,244	192.12
192.13 19213	MGH EXPRESS	859,262	0	287,959	1,147,221	198,930	192.13
192.14 19210	MGH PHYS PRACT MGMT	1,711,154	0	282,239	1,993,393	345,658	192.14
192.15 19215	MGH MARION SURGEONS	1,912,724	0	532,472	2,445,196	424,002	192.15
192.16 19216	MGH MGH MED ONC	1,394,165	0	407,485	1,801,650	312,410	192.16
192.17 19217	MGH FMC SOUTH	2,949,485	0	695,110	3,644,595	631,980	192.17
192.18 19218	MGH FAIRMED ASSOC	368,412	0	81,070	449,482	77,941	192.18
192.19 19219	MGH FMC MARION	786,285	0	199,393	985,678	170,919	192.19
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet B
Part I
Date/Time Prepared:
11/25/2019 10:38 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
193.01 19301 MGH FMC NORTHWOOD	1,297,091	0		334,694	1,631,785	282,955	193.01
193.02 19302 MGH FMC GAS CITY	817,670	0		187,593	1,005,263	174,315	193.02
193.03 19303 MGH HOSPITALISTS	4,341,147	0		726,755	5,067,902	878,784	193.03
193.04 19304 MGH MAR FAM PRACT	3,090,043	0		744,837	3,834,880	664,976	193.04
193.05 19305 MGH FMC SWAYZEE	246,603	0		54,957	301,560	52,291	193.05
193.06 19306 MGH PEDIATRIC CTR	1,012,020	0		221,108	1,233,128	213,827	193.06
193.07 19307 MGH SPECIALTY PHYS	294,592	0		78,847	373,439	64,755	193.07
193.08 19308 MGH FMC CONVERSE	325,798	0		67,417	393,215	68,184	193.08
193.09 19309 MGH UPLAND HEALTH	1,773,125	0		405,557	2,178,682	377,788	193.09
193.10 19310 MGH MGH WOMENS CTR	0	0		0	0	0	193.10
193.11 19311 MGH MGH PSYCHIATRY	0	0		0	0	0	193.11
193.12 19312 OB/GYN	2,885,020	0		642,339	3,527,359	611,651	193.12
193.15 19315 MGH RIVER VIEW BLDG	0	0		0	0	0	193.15
193.16 19316 MGH NEONATOLOGY	656,500	0		0	656,500	113,838	193.16
193.18 19318 MGH WOUND CARE	22,067	0		6,465	28,532	4,948	193.18
194.00 07963 HEART FAILURE CLINIC	53,741	0		11,349	65,090	11,287	194.00
194.01 07950 MOW	0	0		0	0	0	194.01
194.02 07951 MENTAL HEALTH	0	0		0	0	0	194.02
194.03 07952 ADVERTISING	285,794	0		50,251	336,045	58,271	194.03
194.04 07953 MGH WORK SOLUTIONS	948,567	0		188,737	1,137,304	197,211	194.04
194.05 07954 MGH TAYLOR UNIVERSITY	160,861	0		44,383	205,244	35,590	194.05
194.08 07957 MGH SMMP BLDG	0	0		0	0	0	194.08
194.09 07958 MGH AMBUCARE BLDG	0	0		0	0	0	194.09
194.10 07959 MGH 106 LYONS BLDG	6,498	0		0	6,498	1,127	194.10
194.11 07960 FAIRMOUNT	0	0		0	0	0	194.11
194.12 07961 GAS CITY	0	0		0	0	0	194.12
194.13 07969 LYONS	0	0		0	0	0	194.13
194.14 07964 WABASH	0	0		0	0	0	194.14
194.15 07965 TOBACCO GRANT	66,897	0		15,601	82,498	14,305	194.15
194.16 07966 HRSA NETWORK DEV PLANNING	83,649	0		7,689	91,338	15,838	194.16
194.17 07967 HRSA OPIOID PLANNING	88,035	0		3,251	91,286	15,829	194.17
200.00 Cross Foot Adjustments					0		200.00
201.00 Negative Cost Centers		0		0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	160,048,867	12,381,534		19,088,470	160,048,867	23,667,711	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0011		Period: From 07/01/2018 To 06/30/2019		Worksheet B Part I Date/Time Prepared: 11/25/2019 10:38 am	
Cost Center Description			MAINTENANCE & REPAIRS	CAFETERIA	CAFETERIA	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			6.00	6.01	6.02	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
6.01	00601	CAFETERIA	0	1,779,631				6.01
6.02	00602	CAFETERIA	0	1,715,868	1,715,868			6.02
7.00	00700	OPERATION OF PLANT	0	0	43,936	10,493,488		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	115,754	650,135	8.00
9.00	00900	HOUSEKEEPING	0	0	0	178,589	0	9.00
10.00	01000	DIETARY	0	0	24	366,601	0	10.00
13.00	01300	NURSING ADMINISTRATION	0	0	27,984	38,128	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	9,508	130,545	8,787	14.00
15.00	01500	PHARMACY	0	0	91,605	168,181	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	270,393	2,366,473	146,007	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	82,433	548,915	33,283	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41,378	525,085	18,795	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	39,664	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	244,307	1,887,404	101,461	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	118,280	1,133,220	51,631	54.00
57.00	05700	CT SCAN	0	0	25,235	82,447	21,862	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	12,248	97,731	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	27,753	276,101	7,298	59.00
60.00	06000	LABORATORY	0	0	111,147	717,425	18	60.00
60.01	06001	ONCOLOGY	0	0	0	0	5,248	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	0	0	48,133	244,054	5,584	65.00
66.00	06600	PHYSICAL THERAPY	0	0	31,901	48,263	17,915	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	44,297	435,736	4,812	69.00
69.01	06901	CARDIAC REHAB	0	0	8,155	71,052	0	69.01
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
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	11,948	155,143	3,207	90.00
91.00	09100	EMERGENCY	0	0	173,977	606,491	193,544	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	62,493	227,345	26,865	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,715,868	1,526,799	10,420,683	646,317	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1,318	72,805	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	VISITOR MEALS	0	63,763	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	0	0	0	192.03
192.04	19204	LIFELINE	0	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	0	0	0	0	0	192.05
192.06	19206	UROLOGY	0	0	24,188	0	0	192.06
192.08	19211	PARISH NURSING	0	0	1,951	0	0	192.08
192.09	19212	BIOETHICS GRANT	0	0	0	0	0	192.09
192.10	19214	BREAST PUMPS	0	0	0	0	0	192.10
192.11	19208	MGH EMERGENCY PHYSICIANS	0	0	0	0	0	192.11
192.12	19209	LUNG CENTER	0	0	10,671	0	0	192.12
192.13	19213	MGH EXPRESS	0	0	0	0	877	192.13
192.14	19210	MGH PHYS PRACT MGMT	0	0	63,866	0	0	192.14
192.15	19215	MGH MARION SURGEONS	0	0	30,421	0	0	192.15
192.16	19216	MGH MGH MED ONC	0	0	0	0	0	192.16
192.17	19217	MGH FMC SOUTH	0	0	0	0	176	192.17
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	0	39	192.18
192.19	19219	MGH FMC MARION	0	0	21,022	0	0	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	0	0	0	0	0	193.01
193.02	19302	MGH FMC GAS CITY	0	0	0	0	257	193.02
193.03	19303	MGH HOSPITALISTS	0	0	0	0	0	193.03
193.04	19304	MGH MAR FAM PRACT	0	0	0	0	795	193.04
193.05	19305	MGH FMC SWAYZEE	0	0	0	0	11	193.05

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0011

Period:
From 07/01/2018
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Cost Center Description		MAINTENANCE & REPAIRS	CAFETERIA	CAFETERIA	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		6.00	6.01	6.02	7.00	8.00	
193.06	19306	0	0	18,258	0	41	193.06
193.07	19307	0	0	5,550	0	0	193.07
193.08	19308	0	0	0	0	23	193.08
193.09	19309	0	0	0	0	1,501	193.09
193.10	19310	0	0	0	0	0	193.10
193.11	19311	0	0	0	0	0	193.11
193.12	19312	0	0	0	0	0	193.12
193.15	19315	0	0	0	0	0	193.15
193.16	19316	0	0	0	0	0	193.16
193.18	19318	0	0	0	0	0	193.18
194.00	07963	0	0	0	0	0	194.00
194.01	07950	0	0	0	0	0	194.01
194.02	07951	0	0	0	0	0	194.02
194.03	07952	0	0	7,754	0	0	194.03
194.04	07953	0	0	0	0	98	194.04
194.05	07954	0	0	0	0	0	194.05
194.08	07957	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07959	0	0	0	0	0	194.10
194.11	07960	0	0	0	0	0	194.11
194.12	07961	0	0	0	0	0	194.12
194.13	07969	0	0	0	0	0	194.13
194.14	07964	0	0	0	0	0	194.14
194.15	07965	0	0	2,177	0	0	194.15
194.16	07966	0	0	1,407	0	0	194.16
194.17	07967	0	0	486	0	0	194.17
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		0	1,779,631	1,715,868	10,493,488	650,135	202.00
TOTAL (sum lines 118 through 201)		0	1,779,631	1,715,868	10,493,488	650,135	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0011		Period: From 07/01/2018 To 06/30/2019		Worksheet B Part I Date/Time Prepared: 11/25/2019 10:38 am	
Cost Center Description			HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			9.00	10.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
6.01	00601	CAFETERIA						6.01
6.02	00602	CAFETERIA						6.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	3,276,117					9.00
10.00	01000	DIETARY	48,223	1,330,251				10.00
13.00	01300	NURSING ADMINISTRATION	15,070	0	1,520,171			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	75,348	0	0	856,264		14.00
15.00	01500	PHARMACY	42,195	0	0	0	5,557,978	15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	699,226	812,965	368,293	119,872	0	30.00
31.00	03100	INTENSIVE CARE UNIT	192,890	134,367	112,280	34,251	0	31.00
40.00	04000	SUBPROVIDER - I PF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	168,779	120,516	56,360	8,563	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	54,026	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	446,058	0	332,766	51,376	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	207,960	0	0	25,688	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	60,278	0	37,802	34,251	0	59.00
60.00	06000	LABORATORY	168,779	0	0	51,376	0	60.00
60.01	06001	ONCOLOGY	0	0	0	8,563	0	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	126,584	0	65,561	51,376	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	43,451	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	81,375	0	60,337	25,688	0	69.00
69.01	06901	CARDIAC REHAB	90,417	0	11,108	0	0	69.01
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	5,557,978	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	60,278	0	16,274	0	0	90.00
91.00	09100	EMERGENCY	723,337	18,384	236,612	34,251	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	21,097	0	85,121	8,563	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,227,894	1,086,232	1,479,991	453,818	5,557,978	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,028	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	VISITOR MEALS	0	0	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	6,798	0	0	192.03
192.04	19204	LIFELINE	0	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	12,056	0	0	0	0	192.05
192.06	19206	UROLOGY	0	0	0	25,688	0	192.06
192.08	19211	PARISH NURSING	6,028	0	0	0	0	192.08
192.09	19212	BIOTERRORISM GRANT	0	0	0	0	0	192.09
192.10	19214	BREAST PUMPS	0	0	0	0	0	192.10
192.11	19208	MGH EMERGENCY PHYSICIANS	0	0	0	0	0	192.11
192.12	19209	LUNG CENTER	0	0	0	0	0	192.12
192.13	19213	MGH EXPRESS	0	0	33,382	0	0	192.13
192.14	19210	MGH PHYS PRACT MGMT	24,111	0	0	0	0	192.14
192.15	19215	MGH MARION SURGEONS	0	0	0	34,251	0	192.15
192.16	19216	MGH MGH MED ONC	0	0	0	0	0	192.16
192.17	19217	MGH FMC SOUTH	0	0	0	34,251	0	192.17
192.18	19218	MGH FAIRMED ASSOC	0	0	0	0	0	192.18
192.19	19219	MGH FMC MARION	0	0	0	17,125	0	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	0	0	0	8,563	0	193.01
193.02	19302	MGH FMC GAS CITY	0	0	0	17,125	0	193.02
193.03	19303	MGH HOSPITALISTS	0	0	0	0	0	193.03
193.04	19304	MGH MARFAM PRACT	0	0	0	34,251	0	193.04

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
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Cost Center Description	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
	9.00	10.00	13.00	14.00	15.00	
193.05 19305 MGH FMC SWAYZEE	0	0	0	17,125	0	193.05
193.06 19306 MGH PEDIATRIC CTR	0	0	0	8,563	0	193.06
193.07 19307 MGH SPECIALTY PHYS	0	0	0	0	0	193.07
193.08 19308 MGH FMC CONVERSE	0	0	0	8,563	0	193.08
193.09 19309 MGH UPLAND HEALTH	0	0	0	51,376	0	193.09
193.10 19310 MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11 19311 MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12 19312 OB/GYN	0	0	0	94,189	0	193.12
193.15 19315 MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
193.16 19316 MGH NEONATOLOGY	0	0	0	0	0	193.16
193.18 19318 MGH WOUND CARE	0	0	0	0	0	193.18
194.00 07963 HEART FAULTURE CLINIC	0	0	0	0	0	194.00
194.01 07950 MOW	0	92,917	0	0	0	194.01
194.02 07951 MENTAL HEALTH	0	151,102	0	0	0	194.02
194.03 07952 ADVERTISING	0	0	0	0	0	194.03
194.04 07953 MGH WORK SOLUTIONS	0	0	0	34,251	0	194.04
194.05 07954 MGH TAYLOR UNIVERSITY	0	0	0	0	0	194.05
194.08 07957 MGH SMMP BLDG	0	0	0	0	0	194.08
194.09 07958 MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10 07959 MGH 106 LYONS BLDG	0	0	0	0	0	194.10
194.11 07960 FAIRMOUNT	0	0	0	0	0	194.11
194.12 07961 GAS CITY	0	0	0	0	0	194.12
194.13 07969 LYONS	0	0	0	0	0	194.13
194.14 07964 WABASH	0	0	0	0	0	194.14
194.15 07965 TOBACCO GRANT	0	0	0	0	0	194.15
194.16 07966 HRSA NETWORK DEV PLANNING	0	0	0	0	0	194.16
194.17 07967 HRSA OPIOID PLANNING	0	0	0	17,125	0	194.17
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	3,276,117	1,330,251	1,520,171	856,264	5,557,978	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
6.01	00601	CAFETERIA			6.01
6.02	00602	CAFETERIA			6.02
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
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	17,731,170	0	17,731,170
31.00	03100	INTENSIVE CARE UNIT	5,293,276	0	5,293,276
40.00	04000	SUBPROVIDER - IPF	0	0	0
41.00	04100	SUBPROVIDER - IRF	3,701,486	0	3,701,486
42.00	04200	SUBPROVIDER	0	0	0
43.00	04300	NURSERY	1,737,011	0	1,737,011
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	18,353,493	0	18,353,493
51.00	05100	RECOVERY ROOM	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,923,268	0	8,923,268
57.00	05700	CT SCAN	1,617,573	0	1,617,573
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	909,968	0	909,968
59.00	05900	CARDIAC CATHETERIZATION	2,920,214	0	2,920,214
60.00	06000	LABORATORY	11,568,725	0	11,568,725
60.01	06001	ONCOLOGY	2,269,621	0	2,269,621
60.02	06002	RADIATION ONCOLOGY	0	0	0
65.00	06500	RESPIRATORY THERAPY	3,672,833	0	3,672,833
66.00	06600	PHYSICAL THERAPY	3,206,668	0	3,206,668
69.00	06900	ELECTROCARDIOLOGY	2,390,936	0	2,390,936
69.01	06901	CARDIAC REHAB	507,865	0	507,865
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	15,041,052	0	15,041,052
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1,413,078	0	1,413,078
91.00	09100	EMERGENCY	11,259,030	0	11,259,030
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	2,302,505	0	2,302,505
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	114,819,772	0	114,819,772
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	194,145	0	194,145
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0
192.02	19202	VISITOR MEALS	63,763	0	63,763
192.03	19203	GREAT BEGINNINGS/MATERNAL	163,431	0	163,431
192.04	19204	LIFELINE	-109,424	0	-109,424
192.05	19205	OWNED PROPERTIES	278,849	0	278,849
192.06	19206	UROLOGY	1,938,207	0	1,938,207
192.08	19211	PARISH NURSING	78,289	0	78,289
192.09	19212	BIO-TERRORISM GRANT	0	0	0
192.10	19214	BREAST PUMPS	0	0	0
192.11	19208	MGH EMERGENCY PHYSICIANS	0	0	0
192.12	19209	LUNG CENTER	1,054,433	0	1,054,433
192.13	19213	MGH EXPRESS	1,380,410	0	1,380,410
192.14	19210	MGH PHYS PRACT MGMT	2,427,028	0	2,427,028
192.15	19215	MGH MARION SURGEONS	2,933,870	0	2,933,870
192.16	19216	MGH MGH MED ONC	2,114,060	0	2,114,060
192.17	19217	MGH FMC SOUTH	4,311,002	0	4,311,002
192.18	19218	MGH FAIRM MED ASSOC	527,462	0	527,462
192.19	19219	MGH FMC MARION	1,194,744	0	1,194,744
193.00	19300	NONPAID WORKERS	0	0	0
193.01	19301	MGH FMC NORTHWOOD	1,923,303	0	1,923,303
193.02	19302	MGH FMC GAS CITY	1,196,960	0	1,196,960

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
193.03	19303	MGH HOSPITALISTS	5,946,686	0	5,946,686	193.03
193.04	19304	MGH MARFAM PRACT	4,534,902	0	4,534,902	193.04
193.05	19305	MGH FMC SWAYZEE	370,987	0	370,987	193.05
193.06	19306	MGH PEDIATRIC CTR	1,473,817	0	1,473,817	193.06
193.07	19307	MGH SPECIALTY PHYS	443,744	0	443,744	193.07
193.08	19308	MGH FMC CONVERSE	469,985	0	469,985	193.08
193.09	19309	MGH UPLAND HEALTH	2,609,347	0	2,609,347	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	193.11
193.12	19312	OB/GYN	4,233,199	0	4,233,199	193.12
193.15	19315	MGH RIVERVIEW BLDG	0	0	0	193.15
193.16	19316	MGH NEONATOLOGY	770,338	0	770,338	193.16
193.18	19318	MGH WOUND CARE	33,480	0	33,480	193.18
194.00	07963	HEART FAILURE CLINIC	76,377	0	76,377	194.00
194.01	07950	MOW	92,917	0	92,917	194.01
194.02	07951	MENTAL HEALTH	151,102	0	151,102	194.02
194.03	07952	ADVERTISING	402,070	0	402,070	194.03
194.04	07953	MGH WORK SOLUTIONS	1,368,864	0	1,368,864	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	240,834	0	240,834	194.05
194.08	07957	MGH SMMP BLDG	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	7,625	0	7,625	194.10
194.11	07960	FAIRMOUNT	0	0	0	194.11
194.12	07961	GASCITY	0	0	0	194.12
194.13	07969	LYONS	0	0	0	194.13
194.14	07964	WABASH	0	0	0	194.14
194.15	07965	TOBACCO GRANT	98,980	0	98,980	194.15
194.16	07966	HRSA NETWORK DEV PLANNING	108,583	0	108,583	194.16
194.17	07967	HRSA OPIOID PLANNING	124,726	0	124,726	194.17
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)	160,048,867	0	160,048,867	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet B Part II Date/Time Prepared: 11/25/2019 10:38 am
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	467,893	467,893	467,893	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	2,027,894	2,027,894	56,964	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
6.01	00601	CAFETERIA	0	163,071	163,071	0	6.01
6.02	00602	CAFETERIA	0	0	0	0	6.02
7.00	00700	OPERATION OF PLANT	0	3,291,499	3,291,499	4,766	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	70,943	70,943	0	8.00
9.00	00900	HOUSEKEEPING	0	109,453	109,453	0	9.00
10.00	01000	DIETARY	0	224,680	224,680	8	10.00
13.00	01300	NURSING ADMINISTRATION	0	23,368	23,368	6,230	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	80,008	80,008	955	14.00
15.00	01500	PHARMACY	0	103,073	103,073	19,559	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	1,450,347	1,450,347	45,124	30.00
31.00	03100	INTENSIVE CARE UNIT	0	336,415	336,415	14,148	31.00
40.00	04000	SUBPROVIDER - I/PF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - I/RP	0	321,811	321,811	7,692	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	6,965	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,156,739	1,156,739	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	694,520	694,520	17,191	54.00
57.00	05700	CT SCAN	0	50,529	50,529	3,698	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	59,897	59,897	1,845	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	169,215	169,215	4,438	59.00
60.00	06000	LABORATORY	0	439,690	439,690	15,614	60.00
60.01	06001	ONCOLOGY	0	0	0	7,275	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	0	149,574	149,574	8,965	65.00
66.00	06600	PHYSICAL THERAPY	0	29,579	29,579	12,939	66.00
69.00	06900	ELECTROCARDIOLOGY	0	267,051	267,051	6,037	69.00
69.01	06901	CARDIAC REHAB	0	43,546	43,546	1,189	69.01
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
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	95,083	95,083	1,963	90.00
91.00	09100	EMERGENCY	0	371,702	371,702	52,424	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	139,334	139,334	7,501	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	12,336,914	12,336,914	303,490	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	44,620	44,620	205	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.02	19202	VISITOR MEALS	0	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	0	715	192.03
192.04	19204	LIFELINE	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	0	0	0	0	192.05
192.06	19206	UROLOGY	0	0	0	6,662	192.06
192.08	19211	PARI SH NURSING	0	0	0	222	192.08
192.09	19212	BIOTERRORISM GRANT	0	0	0	0	192.09
192.10	19214	BREAST PUMPS	0	0	0	0	192.10
192.11	19208	MGH EMERGENCY PHYSICIANS	0	0	0	0	192.11
192.12	19209	LUNG CENTER	0	0	0	2,721	192.12
192.13	19213	MGH EXPRESS	0	0	0	7,059	192.13
192.14	19210	MGH PHYS PRACT MGMT	0	0	0	6,918	192.14
192.15	19215	MGH MARION SURGEONS	0	0	0	13,052	192.15
192.16	19216	MGH MGH MED ONC	0	0	0	9,989	192.16
192.17	19217	MGH FMC SOUTH	0	0	0	17,039	192.17
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	1,987	192.18
192.19	19219	MGH FMC MARION	0	0	0	4,888	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	0	0	0	8,204	193.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet B
Part II
Date/Time Prepared:
11/25/2019 10:38 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
		0	1.00				
193.02 19302 MGH FMC GAS CITY	0	0	0	0	4,598	15,355	193.02
193.03 19303 MGH HOSPITALISTS	0	0	0	0	17,815	77,412	193.03
193.04 19304 MGH MAR FAM PRACT	0	0	0	0	18,258	58,578	193.04
193.05 19305 MGH FMC SWAYZEE	0	0	0	0	1,347	4,606	193.05
193.06 19306 MGH PEDIATRIC CTR	0	0	0	0	5,420	18,836	193.06
193.07 19307 MGH SPECIALTY PHYS	0	0	0	0	1,933	5,704	193.07
193.08 19308 MGH FMC CONVERSE	0	0	0	0	1,653	6,006	193.08
193.09 19309 MGH UPLAND HEALTH	0	0	0	0	9,941	33,279	193.09
193.10 19310 MGH MGH WOMENS CTR	0	0	0	0	0	0	193.10
193.11 19311 MGH MGH PSYCHIATRY	0	0	0	0	0	0	193.11
193.12 19312 OB/GYN	0	0	0	0	15,745	53,880	193.12
193.15 19315 MGH RIVER VIEW BLDG	0	0	0	0	0	0	193.15
193.16 19316 MGH NEONATOLOGY	0	0	0	0	0	10,028	193.16
193.18 19318 MGH WOUND CARE	0	0	0	0	158	436	193.18
194.00 07963 HEART FAILURE CLINIC	0	0	0	0	278	994	194.00
194.01 07950 MOW	0	0	0	0	0	0	194.01
194.02 07951 MENTAL HEALTH	0	0	0	0	0	0	194.02
194.03 07952 ADVERTISING	0	0	0	0	1,232	5,133	194.03
194.04 07953 MGH WORK SOLUTIONS	0	0	0	0	4,626	17,372	194.04
194.05 07954 MGH TAYLOR UNIVERSITY	0	0	0	0	1,088	3,135	194.05
194.08 07957 MGH SMMP BLDG	0	0	0	0	0	0	194.08
194.09 07958 MGH AMBUCARE BLDG	0	0	0	0	0	0	194.09
194.10 07959 MGH 106 LYONS BLDG	0	0	0	0	0	99	194.10
194.11 07960 FAIRMOUNT	0	0	0	0	0	0	194.11
194.12 07961 GAS CITY	0	0	0	0	0	0	194.12
194.13 07969 LYONS	0	0	0	0	0	0	194.13
194.14 07964 WABASH	0	0	0	0	0	0	194.14
194.15 07965 TOBACCO GRANT	0	0	0	0	382	1,260	194.15
194.16 07966 HRSA NETWORK DEV PLANNING	0	0	0	0	188	1,395	194.16
194.17 07967 HRSA OPIOID PLANNING	0	0	0	0	80	1,394	194.17
200.00	Cross Foot Adjustments			0			200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	12,381,534	12,381,534	467,893	2,084,858	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet B Part II Date/Time Prepared: 11/25/2019 10:38 am			
Cost Center Description		MAINTENANCE & REPAIRS	CAFETERIA	CAFETERIA	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		6.00	6.01	6.02	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
6.01	00601	CAFETERIA	0	186,238			6.01
6.02	00602	CAFETERIA	0	179,565	179,565		6.02
7.00	00700	OPERATION OF PLANT	0	0	4,598	3,436,892	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	37,913	115,812
9.00	00900	HOUSEKEEPING	0	0	0	58,493	0
10.00	01000	DIETARY	0	0	3	120,071	0
13.00	01300	NURSING ADMINISTRATION	0	0	2,928	12,488	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	995	42,757	1,565
15.00	01500	PHARMACY	0	0	9,586	55,084	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	28,296	775,082	26,009
31.00	03100	INTENSIVE CARE UNIT	0	0	8,627	179,784	5,929
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	0	4,330	171,979	3,348
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	4,151	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	25,567	618,174	18,074
51.00	05100	RECOVERY ROOM	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	12,378	371,159	9,197
57.00	05700	CT SCAN	0	0	2,641	27,004	3,894
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	1,282	32,009	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	2,904	90,430	1,300
60.00	06000	LABORATORY	0	0	11,631	234,975	3
60.01	06001	ONCOLOGY	0	0	0	0	935
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	5,037	79,934	995
66.00	06600	PHYSICAL THERAPY	0	0	3,338	15,807	3,191
69.00	06900	ELECTROCARDIOLOGY	0	0	4,636	142,715	857
69.01	06901	CARDIAC REHAB	0	0	853	23,271	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	1,250	50,813	571
91.00	09100	EMERGENCY	0	0	18,207	198,642	34,479
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	6,540	74,462	4,786
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	179,565	159,778	3,413,046	115,133
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	138	23,846	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.02	19202	VISITOR MEALS	0	6,673	0	0	0
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	0	0	0
192.04	19204	LIFELINE	0	0	0	0	0
192.05	19205	OWNED PROPERTIES	0	0	0	0	0
192.06	19206	UROLOGY	0	0	2,531	0	0
192.08	19211	PARI SH NURSING	0	0	204	0	0
192.09	19212	BIO TERRORISM GRANT	0	0	0	0	0
192.10	19214	BREAST PUMPS	0	0	0	0	0
192.11	19208	MGH EMERGENCY PHYSICIANS	0	0	0	0	0
192.12	19209	LUNG CENTER	0	0	1,117	0	0
192.13	19213	MGH EXPRESS	0	0	0	0	156
192.14	19210	MGH PHYS PRACT MGMT	0	0	6,684	0	0
192.15	19215	MGH MARION SURGEONS	0	0	3,184	0	0
192.16	19216	MGH MGH MED ONC	0	0	0	0	0
192.17	19217	MGH FMC SOUTH	0	0	0	0	31
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	0	7
192.19	19219	MGH FMC MARION	0	0	2,200	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	MGH FMC NORTHWOOD	0	0	0	0	0
193.02	19302	MGH FMC GAS CITY	0	0	0	0	46
193.03	19303	MGH HOSPITALISTS	0	0	0	0	0
193.04	19304	MGH MAR FAM PRACT	0	0	0	0	142
193.05	19305	MGH FMC SWAYZEE	0	0	0	0	2

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet B
Part II
Date/Time Prepared:
11/25/2019 10:38 am

Cost Center Description		MAINTENANCE & REPAIRS	CAFETERIA	CAFETERIA	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		6.00	6.01	6.02	7.00	8.00	
193.06	19306	0	0	1,911	0	0	7 193.06
193.07	19307	0	0	581	0	0	0 193.07
193.08	19308	0	0	0	0	4	4 193.08
193.09	19309	0	0	0	0	267	267 193.09
193.10	19310	0	0	0	0	0	0 193.10
193.11	19311	0	0	0	0	0	0 193.11
193.12	19312	0	0	0	0	0	0 193.12
193.15	19315	0	0	0	0	0	0 193.15
193.16	19316	0	0	0	0	0	0 193.16
193.18	19318	0	0	0	0	0	0 193.18
194.00	07963	0	0	0	0	0	0 194.00
194.01	07950	0	0	0	0	0	0 194.01
194.02	07951	0	0	0	0	0	0 194.02
194.03	07952	0	0	811	0	0	0 194.03
194.04	07953	0	0	0	0	17	17 194.04
194.05	07954	0	0	0	0	0	0 194.05
194.08	07957	0	0	0	0	0	0 194.08
194.09	07958	0	0	0	0	0	0 194.09
194.10	07959	0	0	0	0	0	0 194.10
194.11	07960	0	0	0	0	0	0 194.11
194.12	07961	0	0	0	0	0	0 194.12
194.13	07969	0	0	0	0	0	0 194.13
194.14	07964	0	0	0	0	0	0 194.14
194.15	07965	0	0	228	0	0	0 194.15
194.16	07966	0	0	147	0	0	0 194.16
194.17	07967	0	0	51	0	0	0 194.17
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	0 201.00
202.00		0	186,238	179,565	3,436,892	115,812	202.00
	TOTAL (sum lines 118 through 201)	0	186,238	179,565	3,436,892	115,812	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0011		Period: From 07/01/2018 To 06/30/2019		Worksheet B Part II Date/Time Prepared: 11/25/2019 10:38 am	
Cost Center Description			HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			9.00	10.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
6.01	00601	CAFETERIA						6.01
6.02	00602	CAFETERIA						6.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	208,269					9.00
10.00	01000	DIETARY	3,066	359,744				10.00
13.00	01300	NURSING ADMINISTRATION	958	0	64,704			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,790	0	0	139,298		14.00
15.00	01500	PHARMACY	2,682	0	0	0	258,405	15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	44,451	219,853	15,675	19,500	0	30.00
31.00	03100	INTENSIVE CARE UNIT	12,262	36,337	4,779	5,572	0	31.00
40.00	04000	SUBPROVIDER - I PF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	10,730	32,591	2,399	1,393	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	2,300	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	28,357	0	14,164	8,358	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,220	0	0	4,179	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,832	0	1,609	5,572	0	59.00
60.00	06000	LABORATORY	10,730	0	0	8,358	0	60.00
60.01	06001	ONCOLOGY	0	0	0	1,393	0	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	8,047	0	2,791	8,358	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,849	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	5,173	0	2,568	4,179	0	69.00
69.01	06901	CARDIAC REHAB	5,748	0	473	0	0	69.01
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	258,405	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,832	0	693	0	0	90.00
91.00	09100	EMERGENCY	45,985	4,972	10,071	5,572	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,341	0	3,623	1,393	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	205,204	293,753	62,994	73,827	258,405	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	383	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	VISITOR MEALS	0	0	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	289	0	0	192.03
192.04	19204	LIFELINE	0	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	766	0	0	0	0	192.05
192.06	19206	UROLOGY	0	0	0	4,179	0	192.06
192.08	19211	PARI SH NURSING	383	0	0	0	0	192.08
192.09	19212	BIOTERRORISM GRANT	0	0	0	0	0	192.09
192.10	19214	BREAST PUMPS	0	0	0	0	0	192.10
192.11	19208	MGH EMERGENCY PHYSICIANS	0	0	0	0	0	192.11
192.12	19209	LUNG CENTER	0	0	0	0	0	192.12
192.13	19213	MGH EXPRESS	0	0	1,421	0	0	192.13
192.14	19210	MGH PHYS PRACT MGMT	1,533	0	0	0	0	192.14
192.15	19215	MGH MARION SURGEONS	0	0	0	5,572	0	192.15
192.16	19216	MGH MGH MED ONC	0	0	0	0	0	192.16
192.17	19217	MGH FMC SOUTH	0	0	0	5,572	0	192.17
192.18	19218	MGH FAIRMED ASSOC	0	0	0	0	0	192.18
192.19	19219	MGH FMC MARION	0	0	0	2,786	0	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	0	0	0	1,393	0	193.01
193.02	19302	MGH FMC GAS CITY	0	0	0	2,786	0	193.02
193.03	19303	MGH HOSPITALISTS	0	0	0	0	0	193.03
193.04	19304	MGH MAR FAM PRACT	0	0	0	5,572	0	193.04

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet B
Part II
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Cost Center Description	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
	9.00	10.00	13.00	14.00	15.00	
193.05 19305 MGH FMC SWAYZEE	0	0	0	2,786	0	193.05
193.06 19306 MGH PEDIATRIC CTR	0	0	0	1,393	0	193.06
193.07 19307 MGH SPECIALTY PHYS	0	0	0	0	0	193.07
193.08 19308 MGH FMC CONVERSE	0	0	0	1,393	0	193.08
193.09 19309 MGH UPLAND HEALTH	0	0	0	8,358	0	193.09
193.10 19310 MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11 19311 MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12 19312 OB/GYN	0	0	0	15,323	0	193.12
193.15 19315 MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
193.16 19316 MGH NEONATOLOGY	0	0	0	0	0	193.16
193.18 19318 MGH WOUND CARE	0	0	0	0	0	193.18
194.00 07963 HEART FAILURE CLINIC	0	0	0	0	0	194.00
194.01 07950 MOW	0	25,128	0	0	0	194.01
194.02 07951 MENTAL HEALTH	0	40,863	0	0	0	194.02
194.03 07952 ADVERTISING	0	0	0	0	0	194.03
194.04 07953 MGH WORK SOLUTIONS	0	0	0	5,572	0	194.04
194.05 07954 MGH TAYLOR UNIVERSITY	0	0	0	0	0	194.05
194.08 07957 MGH SMMP BLDG	0	0	0	0	0	194.08
194.09 07958 MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10 07959 MGH 106 LYONS BLDG	0	0	0	0	0	194.10
194.11 07960 FAIRMOUNT	0	0	0	0	0	194.11
194.12 07961 GAS CITY	0	0	0	0	0	194.12
194.13 07969 LYONS	0	0	0	0	0	194.13
194.14 07964 WABASH	0	0	0	0	0	194.14
194.15 07965 TOBACCO GRANT	0	0	0	0	0	194.15
194.16 07966 HRSA NETWORK DEV PLANNING	0	0	0	0	0	194.16
194.17 07967 HRSA OPIOID PLANNING	0	0	0	2,786	0	194.17
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)	208,269	359,744	64,704	139,298	258,405	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet B Part II Date/Time Prepared: 11/25/2019 10:38 am
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
6.01	00601	CAFETERIA			6.01
6.02	00602	CAFETERIA			6.02
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
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,792,889	0	2,792,889
31.00	03100	INTENSIVE CARE UNIT	657,940	0	657,940
40.00	04000	SUBPROVIDER - IPF	0	0	0
41.00	04100	SUBPROVIDER - IRF	592,228	0	592,228
42.00	04200	SUBPROVIDER	0	0	0
43.00	04300	NURSERY	34,808	0	34,808
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,068,446	0	2,068,446
51.00	05100	RECOVERY ROOM	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,217,999	0	1,217,999
57.00	05700	CT SCAN	107,137	0	107,137
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	105,447	0	105,447
59.00	05900	CARDIAC CATHETERIZATION	311,541	0	311,541
60.00	06000	LABORATORY	857,947	0	857,947
60.01	06001	ONCOLOGY	38,968	0	38,968
60.02	06002	RADIATION ONCOLOGY	0	0	0
65.00	06500	RESPIRATORY THERAPY	304,466	0	304,466
66.00	06600	PHYSICAL THERAPY	106,604	0	106,604
69.00	06900	ELECTROCARDIOLOGY	455,850	0	455,850
69.01	06901	CARDIAC REHAB	79,339	0	79,339
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	381,853	0	381,853
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	169,387	0	169,387
91.00	09100	EMERGENCY	862,760	0	862,760
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	263,336	0	263,336
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,408,945	0	11,408,945
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	70,676	0	70,676
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0
192.02	19202	VISITOR MEALS	6,673	0	6,673
192.03	19203	GREAT BEGINNINGS/MATERNAL	3,043	0	3,043
192.04	19204	LIFELINE	0	0	0
192.05	19205	OWNED PROPERTIES	4,239	0	4,239
192.06	19206	UROLOGY	37,954	0	37,954
192.08	19211	PARI SH NURSING	1,724	0	1,724
192.09	19212	BOTERRORISM GRANT	0	0	0
192.10	19214	BREAST PUMPS	0	0	0
192.11	19208	MGH EMERGENCY PHYSICIANS	0	0	0
192.12	19209	LUNG CENTER	17,425	0	17,425
192.13	19213	MGH EXPRESS	26,160	0	26,160
192.14	19210	MGH PHYS PRACT MGMT	45,584	0	45,584
192.15	19215	MGH MARION SURGEONS	59,158	0	59,158
192.16	19216	MGH MGH MED ONC	37,509	0	37,509
192.17	19217	MGH FMC SOUTH	78,313	0	78,313
192.18	19218	MGH FAIRM MED ASSOC	8,860	0	8,860
192.19	19219	MGH FMC MARION	24,930	0	24,930
193.00	19300	NONPAID WORKERS	0	0	0
193.01	19301	MGH FMC NORTHWOOD	34,523	0	34,523
193.02	19302	MGH FMC GAS CITY	22,785	0	22,785

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
193.03	19303	MGH HOSPITALISTS	95,227	0	95,227	193.03
193.04	19304	MGH MARFAM PRACT	82,550	0	82,550	193.04
193.05	19305	MGH FMC SWAYZEE	8,741	0	8,741	193.05
193.06	19306	MGH PEDIATRIC CTR	27,567	0	27,567	193.06
193.07	19307	MGH SPECIALTY PHYS	8,218	0	8,218	193.07
193.08	19308	MGH FMC CONVERSE	9,056	0	9,056	193.08
193.09	19309	MGH UPLAND HEALTH	51,845	0	51,845	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	193.11
193.12	19312	OB/GYN	84,948	0	84,948	193.12
193.15	19315	MGH RIVERVIEW BLDG	0	0	0	193.15
193.16	19316	MGH NEONATOLOGY	10,028	0	10,028	193.16
193.18	19318	MGH WOUND CARE	594	0	594	193.18
194.00	07963	HEART FAILURE CLINIC	1,272	0	1,272	194.00
194.01	07950	MOW	25,128	0	25,128	194.01
194.02	07951	MENTAL HEALTH	40,863	0	40,863	194.02
194.03	07952	ADVERTISING	7,176	0	7,176	194.03
194.04	07953	MGH WORK SOLUTIONS	27,587	0	27,587	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	4,223	0	4,223	194.05
194.08	07957	MGH SMMP BLDG	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	99	0	99	194.10
194.11	07960	FAIRMOUNT	0	0	0	194.11
194.12	07961	GAS CITY	0	0	0	194.12
194.13	07969	LYONS	0	0	0	194.13
194.14	07964	WABASH	0	0	0	194.14
194.15	07965	TOBACCO GRANT	1,870	0	1,870	194.15
194.16	07966	HRSA NETWORK DEV PLANNING	1,730	0	1,730	194.16
194.17	07967	HRSA OPIOID PLANNING	4,311	0	4,311	194.17
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	12,381,534	0	12,381,534	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
11/25/2019 10:38 am

Cost Center Description	CAPI TAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconci liatio n	ADMI NI STRATI V E & GENERAL (ACCUM. COST)	MAI NTENANCE & REPAI RS (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)					
	1.00	4.00	5A	5.00	6.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	368,779				1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	13,936	65,159,453			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	60,400	7,934,447	-23,667,711	136,490,580	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
6.01 00601	CAFETERIA	4,857	0	0	1,516,642	6.01
6.02 00602	CAFETERIA	0	0	0	0	6.02
7.00 00700	OPERATION OF PLANT	98,036	663,677	0	8,905,347	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	2,113	0	0	455,412	8.00
9.00 00900	HOUSEKEEPING	3,260	0	0	2,639,784	9.00
10.00 01000	DIETARY	6,692	1,133	0	780,127	10.00
13.00 01300	NURSING ADMINISTRATION	696	867,507	0	1,226,339	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	2,383	133,012	0	538,670	14.00
15.00 01500	PHARMACY	3,070	2,723,670	0	4,479,281	15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	43,198	6,283,831	0	11,034,531	30.00
31.00 03100	INTENSIVE CARE UNIT	10,020	1,970,151	0	3,540,864	31.00
40.00 04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - IRF	9,585	1,071,167	0	2,353,848	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	0	969,937	0	1,400,476	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	34,453	0	0	13,030,616	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	20,686	2,393,999	0	6,294,935	54.00
57.00 05700	CT SCAN	1,505	514,994	0	1,268,132	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	1,784	256,948	0	681,769	58.00
59.00 05900	CARDIAC CATHETERIZATION	5,040	617,964	0	2,110,727	59.00
60.00 06000	LABORATORY	13,096	2,174,367	0	8,965,367	60.00
60.01 06001	ONCOLOGY	0	1,013,129	0	1,922,453	60.01
60.02 06002	RADIATION ONCOLOGY	0	0	0	0	60.02
65.00 06500	RESPIRATORY THERAPY	4,455	1,248,429	0	2,668,771	65.00
66.00 06600	PHYSICAL THERAPY	881	1,801,796	0	2,612,181	66.00
69.00 06900	ELECTROCARDIOLOGY	7,954	840,729	0	1,481,752	69.00
69.01 06901	CARDIAC REHAB	1,297	165,633	0	278,790	69.01
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	8,081,692	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	2,832	273,379	0	993,886	90.00
91.00 09100	EMERGENCY	11,071	7,300,383	0	7,902,180	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
92.01 09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	4,150	1,044,519	0	1,594,527	95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	367,450	42,264,801	-23,667,711	98,759,099	293,114
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,329	28,592	0	97,148	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.02 19202	VISITOR MEALS	0	0	0	0	192.02
192.03 19203	GREAT BEGINNINGS/MATERNAL	0	99,627	0	133,486	192.03
192.04 19204	LIFELINE	0	0	109,424	0	192.04
192.05 19205	OWNED PROPERTIES	0	0	0	227,367	192.05
192.06 19206	UROLOGY	0	927,795	0	1,609,279	192.06
192.08 19211	PARISH NURSING	0	30,904	0	59,920	192.08
192.09 19212	BOTERRORISM GRANT	0	0	0	0	192.09
192.10 19214	BREAST PUMPS	0	0	0	0	192.10
192.11 19208	MGH EMERGENCY PHYSICIANS	0	0	0	0	192.11
192.12 19209	LUNG CENTER	0	378,958	0	889,518	192.12
192.13 19213	MGH EXPRESS	0	982,964	0	1,147,221	192.13
192.14 19210	MGH PHYS PRACT MGMT	0	963,439	0	1,993,393	192.14
192.15 19215	MGH MARION SURGEONS	0	1,817,620	0	2,445,196	192.15
192.16 19216	MGH MGH MED ONC	0	1,390,972	0	1,801,650	192.16
192.17 19217	MGH FMC SOUTH	0	2,372,795	0	3,644,595	192.17
192.18 19218	MGH FAIRM MED ASSOC	0	276,738	0	449,482	192.18
192.19 19219	MGH FMC MARION	0	680,637	0	985,678	192.19
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
11/25/2019 10:38 am

Cost Center Description			CAPITAL RELATED COSTS		Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
			NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)				
			1.00	4.00	5A	5.00	6.00	
193.01	19301	MGH FMC NORTHWOOD	0	1,142,494	0	1,631,785	0	193.01
193.02	19302	MGH FMC GAS CITY	0	640,360	0	1,005,263	0	193.02
193.03	19303	MGH HOSPITALISTS	0	2,480,815	0	5,067,902	0	193.03
193.04	19304	MGH MAR FAM PRACT	0	2,542,538	0	3,834,880	0	193.04
193.05	19305	MGH FMC SWAYZEE	0	187,599	0	301,560	0	193.05
193.06	19306	MGH PEDIATRIC CTR	0	754,763	0	1,233,128	0	193.06
193.07	19307	MGH SPECIALTY PHYS	0	269,150	0	373,439	0	193.07
193.08	19308	MGH FMC CONVERSE	0	230,133	0	393,215	0	193.08
193.09	19309	MGH UPLAND HEALTH	0	1,384,389	0	2,178,682	0	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12	19312	OB/GYN	0	2,192,659	0	3,527,359	0	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
193.16	19316	MGH NEONATOLOGY	0	0	0	656,500	0	193.16
193.18	19318	MGH WOUND CARE	0	22,067	0	28,532	0	193.18
194.00	07963	HEART FAILURE CLINIC	0	38,741	0	65,090	0	194.00
194.01	07950	MOW	0	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	0	194.02
194.03	07952	ADVERTISING	0	171,534	0	336,045	0	194.03
194.04	07953	MGH WORK SOLUTIONS	0	644,264	0	1,137,304	0	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	151,504	0	205,244	0	194.05
194.08	07957	MGH SMMP BLDG	0	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	6,498	0	194.10
194.11	07960	FAIRMOUNT	0	0	0	0	0	194.11
194.12	07961	GAS CITY	0	0	0	0	0	194.12
194.13	07969	LYONS	0	0	0	0	0	194.13
194.14	07964	WABASH	0	0	0	0	0	194.14
194.15	07965	TOBACCO GRANT	0	53,256	0	82,498	0	194.15
194.16	07966	HRSA NETWORK DEV PLANNING	0	26,246	0	91,338	0	194.16
194.17	07967	HRSA OPIOID PLANNING	0	11,099	0	91,286	0	194.17
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)	12,381,534	19,088,470		23,667,711	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	33.574401	0.292950		0.173402	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		467,893		2,084,858	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.007181		0.015275	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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
11/25/2019 10:38 am

Cost Center Description		CAFETERIA (MEALS SERVED)	CAFETERIA (HOURS WORKED)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
		6.01	6.02	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
6.01	00601	230,620					6.01
6.02	00602	222,357	1,353,564				6.02
7.00	00700		34,659	191,550			7.00
8.00	00800			2,113	692,615		8.00
9.00	00900			3,260		56,524	9.00
10.00	01000			6,692		832	10.00
13.00	01300		22,075	696		260	13.00
14.00	01400		7,500	2,383	9,361	1,300	14.00
15.00	01500		72,263	3,070		728	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000		213,299	43,198	155,547	12,064	30.00
31.00	03100		65,027	10,020	35,458	3,328	31.00
40.00	04000						40.00
41.00	04100		32,641	9,585	20,023	2,912	41.00
42.00	04200						42.00
43.00	04300		31,289				43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000		192,722	34,453	108,091	7,696	50.00
51.00	05100						51.00
54.00	05400		93,305	20,686	55,005	3,588	54.00
57.00	05700		19,907	1,505	23,291		57.00
58.00	05800		9,662	1,784			58.00
59.00	05900		21,893	5,040	7,775	1,040	59.00
60.00	06000		87,678	13,096	19	2,912	60.00
60.01	06001				5,591		60.01
60.02	06002						60.02
65.00	06500		37,970	4,455	5,949	2,184	65.00
66.00	06600		25,165	881	19,086		66.00
69.00	06900		34,944	7,954	5,126	1,404	69.00
69.01	06901		6,433	1,297		1,560	69.01
71.00	07100						71.00
72.00	07200						72.00
73.00	07300						73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000		9,425	2,832	3,417	1,040	90.00
91.00	09100		137,242	11,071	206,187	12,480	91.00
92.00	09200						92.00
92.01	09201						92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500		49,298	4,150	28,620	364	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00							118.00
SUBTOTALS (SUM OF LINES 1 through 117)		222,357	1,204,416	190,221	688,546	55,692	
NONREIMBURSABLE COST CENTERS							
190.00	19000		1,040	1,329		104	190.00
192.00	19200						192.00
192.02	19202	8,263					192.02
192.03	19203						192.03
192.04	19204						192.04
192.05	19205					208	192.05
192.06	19206		19,081				192.06
192.08	19211		1,539			104	192.08
192.09	19212						192.09
192.10	19214						192.10
192.11	19208						192.11
192.12	19209		8,418				192.12
192.13	19213				934		192.13
192.14	19210		50,381			416	192.14
192.15	19215		23,998				192.15
192.16	19216						192.16
192.17	19217				188		192.17
192.18	19218				42		192.18
192.19	19219		16,583				192.19
193.00	19300						193.00
193.01	19301						193.01
193.02	19302				274		193.02
193.03	19303						193.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
11/25/2019 10:38 am

Cost Center Description			CAFETERIA (MEALS SERVED)	CAFETERIA (HOURS WORKED)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
			6.01	6.02	7.00	8.00	9.00	
193.04	19304	MGH MAR FAM PRACT	0	0	0	847	0	193.04
193.05	19305	MGH FMC SWAYZEE	0	0	0	12	0	193.05
193.06	19306	MGH PEDIATRIC CTR	0	14,403	0	44	0	193.06
193.07	19307	MGH SPECIALTY PHYS	0	4,378	0	0	0	193.07
193.08	19308	MGH FMC CONVERSE	0	0	0	25	0	193.08
193.09	19309	MGH UPLAND HEALTH	0	0	0	1,599	0	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12	19312	OB/GYN	0	0	0	0	0	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
193.16	19316	MGH NEONATOLOGY	0	0	0	0	0	193.16
193.18	19318	MGH WOUND CARE	0	0	0	0	0	193.18
194.00	07963	HEART FAILURE CLINIC	0	0	0	0	0	194.00
194.01	07950	MOW	0	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	0	194.02
194.03	07952	ADVERTISING	0	6,117	0	0	0	194.03
194.04	07953	MGH WORK SOLUTIONS	0	0	0	104	0	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	0	194.05
194.08	07957	MGH SMMP BLDG	0	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	0	194.10
194.11	07960	FAIRMOUNT	0	0	0	0	0	194.11
194.12	07961	GAS CITY	0	0	0	0	0	194.12
194.13	07969	LYONS	0	0	0	0	0	194.13
194.14	07964	WABASH	0	0	0	0	0	194.14
194.15	07965	TOBACCO GRANT	0	1,717	0	0	0	194.15
194.16	07966	HRSA NETWORK DEV PLANNING	0	1,110	0	0	0	194.16
194.17	07967	HRSA OPIOID PLANNING	0	383	0	0	0	194.17
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)	1,779,631	1,715,868	10,493,488	650,135	3,276,117	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.716724	1.267667	54.781979	0.938667	57.959752	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	186,238	179,565	3,436,892	115,812	208,269	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.807554	0.132661	17.942532	0.167210	3.684612	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: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
11/25/2019 10:38 am

Cost Center Description		DIETARY (MEALS SERVED)	NURSING ADMINISTRATIVE (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)		
		10.00	13.00	14.00	15.00		
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
6.01	00601						6.01
6.02	00602						6.02
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
13.00	01300	89,507	0	880,410			13.00
14.00	01400	0	0	100			14.00
15.00	01500	0	0	0	100		15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	54,701	213,299	14	0		30.00
31.00	03100	9,041	65,027	4	0		31.00
40.00	04000	0	0	0	0		40.00
41.00	04100	8,109	32,641	1	0		41.00
42.00	04200	0	0	0	0		42.00
43.00	04300	0	31,289	0	0		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	192,722	6	0		50.00
51.00	05100	0	0	0	0		51.00
54.00	05400	0	0	3	0		54.00
57.00	05700	0	0	0	0		57.00
58.00	05800	0	0	0	0		58.00
59.00	05900	0	21,893	4	0		59.00
60.00	06000	0	0	6	0		60.00
60.01	06001	0	0	1	0		60.01
60.02	06002	0	0	0	0		60.02
65.00	06500	0	37,970	6	0		65.00
66.00	06600	0	25,165	0	0		66.00
69.00	06900	0	34,944	3	0		69.00
69.01	06901	0	6,433	0	0		69.01
71.00	07100	0	0	0	0		71.00
72.00	07200	0	0	0	0		72.00
73.00	07300	0	0	0	100		73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	9,425	0	0		90.00
91.00	09100	1,237	137,034	4	0		91.00
92.00	09200	0	0	0	0		92.00
92.01	09201	0	0	0	0		92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	49,298	1	0		95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0		113.00
118.00		73,088	857,140	53	100		118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0		190.00
192.00	19200	0	0	0	0		192.00
192.02	19202	0	0	0	0		192.02
192.03	19203	0	3,937	0	0		192.03
192.04	19204	0	0	0	0		192.04
192.05	19205	0	0	0	0		192.05
192.06	19206	0	0	3	0		192.06
192.08	19211	0	0	0	0		192.08
192.09	19212	0	0	0	0		192.09
192.10	19214	0	0	0	0		192.10
192.11	19208	0	0	0	0		192.11
192.12	19209	0	0	0	0		192.12
192.13	19213	0	19,333	0	0		192.13
192.14	19210	0	0	0	0		192.14
192.15	19215	0	0	4	0		192.15
192.16	19216	0	0	0	0		192.16
192.17	19217	0	0	4	0		192.17
192.18	19218	0	0	0	0		192.18
192.19	19219	0	0	2	0		192.19
193.00	19300	0	0	0	0		193.00
193.01	19301	0	0	1	0		193.01
193.02	19302	0	0	2	0		193.02

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
11/25/2019 10:38 am

Cost Center Description			DIETARY (MEALS SERVED)	NURSING ADMINISTRATIVE (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	13.00	14.00	15.00	
193.03	19303	MGH HOSPITALISTS	0	0	0	0	193.03
193.04	19304	MGH MAR FAM PRACT	0	0	4	0	193.04
193.05	19305	MGH FMC SWAYZEE	0	0	2	0	193.05
193.06	19306	MGH PEDIATRIC CTR	0	0	1	0	193.06
193.07	19307	MGH SPECIALTY PHYS	0	0	0	0	193.07
193.08	19308	MGH FMC CONVERSE	0	0	1	0	193.08
193.09	19309	MGH UPLAND HEALTH	0	0	6	0	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	193.11
193.12	19312	OB/GYN	0	0	11	0	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	193.15
193.16	19316	MGH NEONATOLOGY	0	0	0	0	193.16
193.18	19318	MGH WOUND CARE	0	0	0	0	193.18
194.00	07963	HEART FAILURE CLINIC	0	0	0	0	194.00
194.01	07950	MOW	6,252	0	0	0	194.01
194.02	07951	MENTAL HEALTH	10,167	0	0	0	194.02
194.03	07952	ADVERTISING	0	0	0	0	194.03
194.04	07953	MGH WORK SOLUTIONS	0	0	4	0	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	194.05
194.08	07957	MGH SMMP BLDG	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	194.10
194.11	07960	FAIRMOUNT	0	0	0	0	194.11
194.12	07961	GAS CITY	0	0	0	0	194.12
194.13	07969	LYONS	0	0	0	0	194.13
194.14	07964	WABASH	0	0	0	0	194.14
194.15	07965	TOBACCO GRANT	0	0	0	0	194.15
194.16	07966	HRSA NETWORK DEV PLANNING	0	0	0	0	194.16
194.17	07967	HRSA OPIOID PLANNING	0	0	2	0	194.17
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)	1,330,251	1,520,171	856,264	5,557,978	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.861977	1.726663	8,562.640000	55,579.780000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	359,744	64,704	139,298	258,405	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.019172	0.073493	1,392.980000	2,584.050000	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: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet C
Part I
Date/Time Prepared:
11/25/2019 10:38 am

		Title XVIII		Hospital		PPS		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
				Total Costs	RCE Disallowance	Total Costs		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,731,170		17,731,170	0	17,731,170	30.00
31.00	03100	INTENSIVE CARE UNIT	5,293,276		5,293,276	0	5,293,276	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	3,701,486		3,701,486	0	3,701,486	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	1,737,011		1,737,011	0	1,737,011	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	18,353,493		18,353,493	0	18,353,493	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,923,268		8,923,268	0	8,923,268	54.00
57.00	05700	CT SCAN	1,617,573		1,617,573	0	1,617,573	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	909,968		909,968	0	909,968	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,920,214		2,920,214	0	2,920,214	59.00
60.00	06000	LABORATORY	11,568,725		11,568,725	0	11,568,725	60.00
60.01	06001	ONCOLOGY	2,269,621		2,269,621	0	2,269,621	60.01
60.02	06002	RADIATION ONCOLOGY	0		0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	3,672,833	0	3,672,833	0	3,672,833	65.00
66.00	06600	PHYSICAL THERAPY	3,206,668	0	3,206,668	0	3,206,668	66.00
69.00	06900	ELECTROCARDIOLOGY	2,390,936		2,390,936	0	2,390,936	69.00
69.01	06901	CARDIAC REHAB	507,865		507,865	0	507,865	69.01
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	15,041,052		15,041,052	0	15,041,052	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,413,078		1,413,078	0	1,413,078	90.00
91.00	09100	EMERGENCY	11,259,030		11,259,030	0	11,259,030	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,558,409		3,558,409	0	3,558,409	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0		0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	2,302,505		2,302,505	0	2,302,505	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	118,378,181	0	118,378,181	0	118,378,181	200.00
201.00		Less Observation Beds	3,558,409		3,558,409		3,558,409	201.00
202.00		Total (see instructions)	114,819,772	0	114,819,772	0	114,819,772	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet C Part I Date/Time Prepared: 11/25/2019 10:38 am
		Title XVIII	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				
	9.00	10.00					
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	17,405,375		17,405,375		30.00
31.00	03100	INTENSIVE CARE UNIT	6,910,126		6,910,126		31.00
40.00	04000	SUBPROVIDER - IPF	0		0		40.00
41.00	04100	SUBPROVIDER - IRF	3,619,018		3,619,018		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	2,486,224		2,486,224		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	33,648,820	74,776,303	108,425,123	0.169273	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,065,720	32,658,868	34,724,588	0.256973	54.00
57.00	05700	CT SCAN	4,515,701	29,293,872	33,809,573	0.047844	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	316,626	2,952,617	3,269,243	0.278342	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,944,950	5,158,912	8,103,862	0.360348	59.00
60.00	06000	LABORATORY	3,729,229	14,380,572	18,109,801	0.638810	60.00
60.01	06001	ONCOLOGY	26,837	7,583,431	7,610,268	0.298231	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0.000000	60.02
65.00	06500	RESPIRATORY THERAPY	2,632,327	6,153,357	8,785,684	0.418047	65.00
66.00	06600	PHYSICAL THERAPY	5,157,649	5,488,208	10,645,857	0.301213	66.00
69.00	06900	ELECTROCARDIOLOGY	3,891,951	8,666,882	12,558,833	0.190379	69.00
69.01	06901	CARDIAC REHAB	1,000	1,079,233	1,080,233	0.470144	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,386,817	83,860,149	92,246,966	0.163052	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	8,000	1,921,237	1,929,237	0.732454	90.00
91.00	09100	EMERGENCY	12,619,694	65,661,719	78,281,413	0.143828	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	8,193,383	8,193,383	0.434303	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0.000000	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	4,423,618	4,423,618	0.520503	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	110,366,064	352,252,361	462,618,425		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	110,366,064	352,252,361	462,618,425		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet C Part I Date/Time Prepared: 11/25/2019 10:38 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio	
		11.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS		30.00
31.00	03100 INTENSIVE CARE UNIT		31.00
40.00	04000 SUBPROVIDER - IPF		40.00
41.00	04100 SUBPROVIDER - IRF		41.00
42.00	04200 SUBPROVIDER		42.00
43.00	04300 NURSERY		43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.169273	50.00
51.00	05100 RECOVERY ROOM	0.000000	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.256973	54.00
57.00	05700 CT SCAN	0.047844	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.278342	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.360348	59.00
60.00	06000 LABORATORY	0.638810	60.00
60.01	06001 ONCOLOGY	0.298231	60.01
60.02	06002 RADIATION ONCOLOGY	0.000000	60.02
65.00	06500 RESPIRATORY THERAPY	0.418047	65.00
66.00	06600 PHYSICAL THERAPY	0.301213	66.00
69.00	06900 ELECTROCARDIOLOGY	0.190379	69.00
69.01	06901 CARDIAC REHAB	0.470144	69.01
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	0.163052	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.732454	90.00
91.00	09100 EMERGENCY	0.143828	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.434303	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000	92.01
OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	0.520503	95.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE		113.00
200.00	Subtotal (see instructions)		200.00
201.00	Less Observation Beds		201.00
202.00	Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet C
Part I
Date/Time Prepared:
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		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	17,731,170		17,731,170	0	17,731,170	30.00
31.00	03100 INTENSIVE CARE UNIT	5,293,276		5,293,276	0	5,293,276	31.00
40.00	04000 SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	04100 SUBPROVIDER - IRF	3,701,486		3,701,486	0	3,701,486	41.00
42.00	04200 SUBPROVIDER	0		0	0	0	42.00
43.00	04300 NURSERY	1,737,011		1,737,011	0	1,737,011	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	18,353,493		18,353,493	0	18,353,493	50.00
51.00	05100 RECOVERY ROOM	0		0	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	8,923,268		8,923,268	0	8,923,268	54.00
57.00	05700 CT SCAN	1,617,573		1,617,573	0	1,617,573	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	909,968		909,968	0	909,968	58.00
59.00	05900 CARDIAC CATHETERIZATION	2,920,214		2,920,214	0	2,920,214	59.00
60.00	06000 LABORATORY	11,568,725		11,568,725	0	11,568,725	60.00
60.01	06001 ONCOLOGY	2,269,621		2,269,621	0	2,269,621	60.01
60.02	06002 RADIATION ONCOLOGY	0		0	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	3,672,833	0	3,672,833	0	3,672,833	65.00
66.00	06600 PHYSICAL THERAPY	3,206,668	0	3,206,668	0	3,206,668	66.00
69.00	06900 ELECTROCARDIOLOGY	2,390,936		2,390,936	0	2,390,936	69.00
69.01	06901 CARDIAC REHAB	507,865		507,865	0	507,865	69.01
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	15,041,052		15,041,052	0	15,041,052	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	1,413,078		1,413,078	0	1,413,078	90.00
91.00	09100 EMERGENCY	11,259,030		11,259,030	0	11,259,030	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3,558,409		3,558,409	0	3,558,409	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0		0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	2,302,505		2,302,505	0	2,302,505	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	118,378,181	0	118,378,181	0	118,378,181	200.00
201.00	Less Observation Beds	3,558,409		3,558,409		3,558,409	201.00
202.00	Total (see instructions)	114,819,772	0	114,819,772	0	114,819,772	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet 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	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	17,405,375		17,405,375		30.00
31.00	03100	INTENSIVE CARE UNIT	6,910,126		6,910,126		31.00
40.00	04000	SUBPROVIDER - IPF	0		0		40.00
41.00	04100	SUBPROVIDER - IRF	3,619,018		3,619,018		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	2,486,224		2,486,224		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	33,648,820	74,776,303	108,425,123	0.169273	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,065,720	32,658,868	34,724,588	0.256973	54.00
57.00	05700	CT SCAN	4,515,701	29,293,872	33,809,573	0.047844	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	316,626	2,952,617	3,269,243	0.278342	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,944,950	5,158,912	8,103,862	0.360348	59.00
60.00	06000	LABORATORY	3,729,229	14,380,572	18,109,801	0.638810	60.00
60.01	06001	ONCOLOGY	26,837	7,583,431	7,610,268	0.298231	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0.000000	60.02
65.00	06500	RESPIRATORY THERAPY	2,632,327	6,153,357	8,785,684	0.418047	65.00
66.00	06600	PHYSICAL THERAPY	5,157,649	5,488,208	10,645,857	0.301213	66.00
69.00	06900	ELECTROCARDIOLOGY	3,891,951	8,666,882	12,558,833	0.190379	69.00
69.01	06901	CARDIAC REHAB	1,000	1,079,233	1,080,233	0.470144	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,386,817	83,860,149	92,246,966	0.163052	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	8,000	1,921,237	1,929,237	0.732454	90.00
91.00	09100	EMERGENCY	12,619,694	65,661,719	78,281,413	0.143828	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	8,193,383	8,193,383	0.434303	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0.000000	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	4,423,618	4,423,618	0.520503	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	110,366,064	352,252,361	462,618,425		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	110,366,064	352,252,361	462,618,425		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet C Part I Date/Time Prepared: 11/25/2019 10:38 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
42.00	04200 SUBPROVIDER			42.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
60.01	06001 ONCOLOGY	0.000000		60.01
60.02	06002 RADIATION ONCOLOGY	0.000000		60.02
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901 CARDIAC REHAB	0.000000		69.01
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
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
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000		92.01
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet D Part I Date/Time Prepared: 11/25/2019 10:38 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,792,889	0	2,792,889	16,907	165.19	30.00
31.00	INTENSIVE CARE UNIT	657,940		657,940	3,749	175.50	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	592,228	0	592,228	2,821	209.94	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	34,808		34,808	1,910	18.22	43.00
200.00	Total (lines 30 through 199)	4,077,865		4,077,865	25,387		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	5,955	983,706				
31.00	INTENSIVE CARE UNIT	1,175	206,213				
40.00	SUBPROVIDER - IPF	0	0				
41.00	SUBPROVIDER - IRF	2,091	438,985				
42.00	SUBPROVIDER	0	0				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	9,221	1,628,904				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet D Part II Date/Time Prepared: 11/25/2019 10:38 am
		Title XVIII		Hospital
				PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	2,068,446	108,425,123	0.019077	12,146,687	231,722	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,217,999	34,724,588	0.035076	934,943	32,794	54.00
57.00	05700 CT SCAN	107,137	33,809,573	0.003169	2,371,789	7,516	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	105,447	3,269,243	0.032254	155,924	5,029	58.00
59.00	05900 CARDIAC CATHETERIZATION	311,541	8,103,862	0.038444	1,330,930	51,166	59.00
60.00	06000 LABORATORY	857,947	18,109,801	0.047375	1,699,007	80,490	60.00
60.01	06001 ONCOLOGY	38,968	7,610,268	0.005120	25,354	130	60.01
60.02	06002 RADIATION ONCOLOGY	0	0	0.000000	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	304,466	8,785,684	0.034655	1,198,096	41,520	65.00
66.00	06600 PHYSICAL THERAPY	106,604	10,645,857	0.010014	1,056,834	10,583	66.00
69.00	06900 ELECTROCARDIOLOGY	455,850	12,558,833	0.036297	1,864,651	67,681	69.00
69.01	06901 CARDIAC REHAB	79,339	1,080,233	0.073446	592	43	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	381,853	92,246,966	0.004139	3,422,438	14,165	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	169,387	1,929,237	0.087800	7,805	685	90.00
91.00	09100 EMERGENCY	862,760	78,281,413	0.011021	5,385,166	59,350	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	560,496	8,193,383	0.068408	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	7,628,240	427,774,064		31,600,216	602,874	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet D Part III Date/Time Prepared: 11/25/2019 10:38 am
Title XVIII		Hospital	PPS

Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00	
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of col. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	16,907	0.00	5,955	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	3,749	0.00	1,175	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	2,821	0.00	2,091	41.00	
42.00	04200	SUBPROVIDER	0	0	0	0.00	0	42.00	
43.00	04300	NURSERY	0	0	1,910	0.00	0	43.00	
200.00		Total (lines 30 through 199)	0	0	25,387	0.00	9,221	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
40.00	04000	SUBPROVIDER - IPF	0						40.00
41.00	04100	SUBPROVIDER - IRF	0						41.00
42.00	04200	SUBPROVIDER	0						42.00
43.00	04300	NURSERY	0						43.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet D
Part IV
Date/Time Prepared:
11/25/2019 10:38 am

Cost Center Description		Title XVIII			Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
		1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	ONCOLOGY	0	0	0	0	0	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01
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
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet D Part IV Date/Time Prepared: 11/25/2019 10:38 am
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Cost Center Description		Title XVIII			Hospital	PPS	
		All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
		4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	108,425,123	0.000000	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0.000000	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	34,724,588	0.000000	54.00
57.00	05700 CT SCAN	0	0	0	33,809,573	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	3,269,243	0.000000	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	8,103,862	0.000000	59.00
60.00	06000 LABORATORY	0	0	0	18,109,801	0.000000	60.00
60.01	06001 ONCOLOGY	0	0	0	7,610,268	0.000000	60.01
60.02	06002 RADIATION ONCOLOGY	0	0	0	0	0.000000	60.02
65.00	06500 RESPIRATORY THERAPY	0	0	0	8,785,684	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	10,645,857	0.000000	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	12,558,833	0.000000	69.00
69.01	06901 CARDIAC REHAB	0	0	0	1,080,233	0.000000	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	92,246,966	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	1,929,237	0.000000	90.00
91.00	09100 EMERGENCY	0	0	0	78,281,413	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	8,193,383	0.000000	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0.000000	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	0	0	0	427,774,064		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet D
Part IV
Date/Time Prepared:
11/25/2019 10:38 am

Cost Center Description		Title XVIII			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 + col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	12,146,687	0	19,730,987	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	934,943	0	8,089,545	0	54.00
57.00	05700 CT SCAN	0.000000	2,371,789	0	7,608,464	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	155,924	0	922,073	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	1,330,930	0	2,013,043	0	59.00
60.00	06000 LABORATORY	0.000000	1,699,007	0	1,989,224	0	60.00
60.01	06001 ONCOLOGY	0.000000	25,354	0	3,310,555	0	60.01
60.02	06002 RADIATION ONCOLOGY	0.000000	0	0	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	0.000000	1,198,096	0	1,803,357	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	1,056,834	0	102,962	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	1,864,651	0	2,466,204	0	69.00
69.01	06901 CARDIAC REHAB	0.000000	592	0	415,104	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	3,422,438	0	40,212,912	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	7,805	0	740,536	0	90.00
91.00	09100 EMERGENCY	0.000000	5,385,166	0	12,728,069	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	1,673,897	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		31,600,216	0	103,806,932	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet D Part V Date/Time Prepared: 11/25/2019 10:38 am
	Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.169273	19,730,987	0	0	3,339,923	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.256973	8,089,545	0	0	2,078,795	54.00
57.00	05700	CT SCAN	0.047844	7,608,464	0	0	364,019	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.278342	922,073	0	0	256,652	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.360348	2,013,043	0	0	725,396	59.00
60.00	06000	LABORATORY	0.638810	1,989,224	136	0	1,270,736	60.00
60.01	06001	ONCOLOGY	0.298231	3,310,555	0	0	987,310	60.01
60.02	06002	RADIATION ONCOLOGY	0.000000	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	0.418047	1,803,357	0	0	753,888	65.00
66.00	06600	PHYSICAL THERAPY	0.301213	102,962	0	0	31,013	66.00
69.00	06900	ELECTROCARDIOLOGY	0.190379	2,466,204	0	0	469,513	69.00
69.01	06901	CARDIAC REHAB	0.470144	415,104	0	0	195,159	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.163052	40,212,912	0	7,086	6,556,796	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.732454	740,536	0	0	542,409	90.00
91.00	09100	EMERGENCY	0.143828	12,728,069	0	0	1,830,653	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.434303	1,673,897	0	0	726,978	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.520503		0			95.00
200.00		Subtotal (see instructions)		103,806,932	136	7,086	20,129,240	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		103,806,932	136	7,086	20,129,240	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet D Part V Date/Time Prepared: 11/25/2019 10:38 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	87	0	60.00
60.01	06001 ONCOLOGY	0	0	60.01
60.02	06002 RADIATION ONCOLOGY	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
69.01	06901 CARDIAC REHAB	0	0	69.01
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	1,155	73.00
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
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	92.01
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0	0	95.00
200.00	Subtotal (see instructions)	87	1,155	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	87	1,155	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0011 Component CCN: 15-T011		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part II Date/Time Prepared: 11/25/2019 10:38 am		
				Title XVIII		Subprovider - IRF	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,068,446	108,425,123	0.019077	34,129	651	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,217,999	34,724,588	0.035076	39,695	1,392	54.00
57.00	05700	CT SCAN	107,137	33,809,573	0.003169	64,633	205	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	105,447	3,269,243	0.032254	7,999	258	58.00
59.00	05900	CARDIAC CATHETERIZATION	311,541	8,103,862	0.038444	2,278	88	59.00
60.00	06000	LABORATORY	857,947	18,109,801	0.047375	73,625	3,488	60.00
60.01	06001	ONCOLOGY	38,968	7,610,268	0.005120	592	3	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0.000000	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	304,466	8,785,684	0.034655	91,240	3,162	65.00
66.00	06600	PHYSICAL THERAPY	106,604	10,645,857	0.010014	2,208,644	22,117	66.00
69.00	06900	ELECTROCARDIOLOGY	455,850	12,558,833	0.036297	54,485	1,978	69.00
69.01	06901	CARDIAC REHAB	79,339	1,080,233	0.073446	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	381,853	92,246,966	0.004139	390,593	1,617	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	169,387	1,929,237	0.087800	88	8	90.00
91.00	09100	EMERGENCY	862,760	78,281,413	0.011021	93,652	1,032	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	8,193,383	0.000000	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	7,067,744	427,774,064		3,061,653	35,999	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0011 Component CCN: 15-T011	Period: From 07/01/2018 To 06/30/2019	Worksheet D Part IV Date/Time Prepared: 11/25/2019 10:38 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 ONCOLOGY	0	0	0	0	0	60.01
60.02	06002 RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901 CARDIAC REHAB	0	0	0	0	0	69.01
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
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00	Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0011 Component CCN: 15-T011	Period: From 07/01/2018 To 06/30/2019	Worksheet D Part IV Date/Time Prepared: 11/25/2019 10:38 am PPS
Title XVIII		Subprovider - IRF	

Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	108,425,123	0.000000	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0.000000	51.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	34,724,588	0.000000	54.00
57.00 05700 CT SCAN	0	0	0	33,809,573	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	3,269,243	0.000000	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	8,103,862	0.000000	59.00
60.00 06000 LABORATORY	0	0	0	18,109,801	0.000000	60.00
60.01 06001 ONCOLOGY	0	0	0	7,610,268	0.000000	60.01
60.02 06002 RADIATION ONCOLOGY	0	0	0	0	0.000000	60.02
65.00 06500 RESPIRATORY THERAPY	0	0	0	8,785,684	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	10,645,857	0.000000	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	12,558,833	0.000000	69.00
69.01 06901 CARDIAC REHAB	0	0	0	1,080,233	0.000000	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	92,246,966	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	1,929,237	0.000000	90.00
91.00 09100 EMERGENCY	0	0	0	78,281,413	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	8,193,383	0.000000	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0.000000	92.01
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0	0	427,774,064		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0011 Component CCN: 15-T011	Period: From 07/01/2018 To 06/30/2019	Worksheet D Part IV Date/Time Prepared: 11/25/2019 10:38 am PPS
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Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	34,129	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	39,695	0	0	0	54.00
57.00	05700 CT SCAN	0.000000	64,633	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	7,999	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	2,278	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	73,625	0	0	0	60.00
60.01	06001 ONCOLOGY	0.000000	592	0	0	0	60.01
60.02	06002 RADIATION ONCOLOGY	0.000000	0	0	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	0.000000	91,240	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	2,208,644	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	54,485	0	0	0	69.00
69.01	06901 CARDIAC REHAB	0.000000	0	0	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	390,593	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	88	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	93,652	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		3,061,653	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/25/2019 10:38 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		16,907	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		16,907	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)		13,514	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		5,955	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		17,731,170	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		17,731,170	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		17,731,170	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)		1,048.75	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		6,245,306	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)		6,245,306	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/25/2019 10:38 am	
Title XVIII			Hospital		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	5,293,276	3,749	1,411.92	1,175	1,659,006	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)					6,538,489	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					14,442,801	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,189,919	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					602,874	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,792,793	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					12,650,008	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					3,393	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,048.75	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					3,558,409	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0011		Period: From 07/01/2018 To 06/30/2019		Worksheet D-1 Date/Time Prepared: 11/25/2019 10:38 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,792,889	17,731,170	0.157513	3,558,409	560,496	90.00
91.00	Nursing School cost	0	17,731,170	0.000000	3,558,409	0	91.00
92.00	Allied health cost	0	17,731,170	0.000000	3,558,409	0	92.00
93.00	All other Medical Education	0	17,731,170	0.000000	3,558,409	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0011 Component CCN: 15-T011	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/25/2019 10:38 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,821	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,821	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)		2,821	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,091	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,701,486	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,701,486	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)		3,701,486	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)		1,312.12	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,743,643	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,743,643	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0011 Component CCN: 15-T011		Period: From 07/01/2018 To 06/30/2019		Worksheet D-1 Date/Time Prepared: 11/25/2019 10:38 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					860,335	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,603,978	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)					438,985	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					35,999	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					474,984	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					3,128,994	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0011 Component CCN: 15-T011		Period: From 07/01/2018 To 06/30/2019		Worksheet D-1 Date/Time Prepared: 11/25/2019 10:38 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	592,228	3,701,486	0.159997	0	0	90.00
91.00	Nursing School cost	0	3,701,486	0.000000	0	0	91.00
92.00	Allied health cost	0	3,701,486	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,701,486	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/25/2019 10:38 am
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			16,907 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			16,907 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)			13,514 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			707 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			1,910 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			17,731,170 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			17,731,170 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			17,731,170 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)			1,048.75 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			741,466 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)			741,466 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0011		Period: From 07/01/2018 To 06/30/2019		Worksheet D-1	
		Title XIX		Hospital		Date/Time Prepared: 11/25/2019 10:38 am	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	1,737,011	1,910	909.43	0	0 42.00	
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	5,293,276	3,749	1,411.92	0	0 43.00	
44.00	CORONARY CARE UNIT					44.00	
45.00	BURN INTENSIVE CARE UNIT					45.00	
46.00	SURGICAL INTENSIVE CARE UNIT					46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00	
Cost Center Description							
		1.00					
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					425,968	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,167,434	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)						0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					3,393	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,048.75	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,558,409	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0011		Period: From 07/01/2018 To 06/30/2019		Worksheet D-1 Date/Time Prepared: 11/25/2019 10:38 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,792,889	17,731,170	0.157513	3,558,409	560,496	90.00
91.00	Nursing School cost	0	17,731,170	0.000000	3,558,409	0	91.00
92.00	Allied health cost	0	17,731,170	0.000000	3,558,409	0	92.00
93.00	All other Medical Education	0	17,731,170	0.000000	3,558,409	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0011 Component CCN: 15-T011	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/25/2019 10:38 am
		Title XIX	Subprovider - IRF	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)			2,821 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,821 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)			2,821 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			174 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			1,910 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			3,701,486 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			3,701,486 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)			3,701,486 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)			1,312.12 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			228,309 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)			228,309 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0011 Component CCN: 15-T011		Period: From 07/01/2018 To 06/30/2019		Worksheet D-1 Date/Time Prepared: 11/25/2019 10:38 am	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	
44.00	CORONARY CARE UNIT						
45.00	BURN INTENSIVE CARE UNIT						
46.00	SURGICAL INTENSIVE CARE UNIT						
47.00	OTHER SPECIAL CARE (SPECIFY)						
Cost Center Description							
		1.00					
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	10,430					
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	238,739					
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					
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0					
52.00	Total Program excludable cost (sum of lines 50 and 51)	0					
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)	0					
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges	0					
55.00	Target amount per discharge	0.00					
56.00	Target amount (line 54 x line 55)	0					
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0					
58.00	Bonus payment (see instructions)	0					
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00					
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00					
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0					
62.00	Relief payment (see instructions)	0					
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0					
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0					
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0					
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0					
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0					
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0					
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0					
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	70.00					
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	71.00					
72.00	Program routine service cost (line 9 x line 71)	72.00					
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	73.00					
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	74.00					
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	75.00					
76.00	Per diem capital-related costs (line 75 ÷ line 2)	76.00					
77.00	Program capital-related costs (line 9 x line 76)	77.00					
78.00	Inpatient routine service cost (line 74 minus line 77)	78.00					
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	79.00					
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	80.00					
81.00	Inpatient routine service cost per diem limitation	81.00					
82.00	Inpatient routine service cost limitation (line 9 x line 81)	82.00					
83.00	Reasonable inpatient routine service costs (see instructions)	83.00					
84.00	Program inpatient ancillary services (see instructions)	84.00					
85.00	Utilization review - physician compensation (see instructions)	85.00					
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	86.00					
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)	0					
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00					
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0					

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0011 Component CCN: 15-T011		Period: From 07/01/2018 To 06/30/2019		Worksheet D-1 Date/Time Prepared: 11/25/2019 10:38 am	
		Title XIX		Subprovider - IRF		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	592,228	3,701,486	0.159997	0	0	90.00
91.00	Nursing School cost	0	3,701,486	0.000000	0	0	91.00
92.00	Allied health cost	0	3,701,486	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,701,486	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/25/2019 10:38 am
		Title XVIII	Hospital	PPS

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		7,487,070	30.00
31.00	03100	INTENSIVE CARE UNIT		2,548,137	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.169273	12,146,687	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.256973	934,943	54.00
57.00	05700	CT SCAN	0.047844	2,371,789	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.278342	155,924	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.360348	1,330,930	59.00
60.00	06000	LABORATORY	0.638810	1,699,007	60.00
60.01	06001	ONCOLOGY	0.298231	25,354	60.01
60.02	06002	RADIATION ONCOLOGY	0.000000	0	60.02
65.00	06500	RESPIRATORY THERAPY	0.418047	1,198,096	65.00
66.00	06600	PHYSICAL THERAPY	0.301213	1,056,834	66.00
69.00	06900	ELECTROCARDIOLOGY	0.190379	1,864,651	69.00
69.01	06901	CARDIAC REHAB	0.470144	592	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.163052	3,422,438	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.732454	7,805	90.00
91.00	09100	EMERGENCY	0.143828	5,385,166	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.434303	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		31,600,216	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)		31,600,216	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0011 Component CCN: 15-T011	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/25/2019 10:38 am	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		2,731,667		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.169273	34,129	5,777	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.256973	39,695	10,201	54.00
57.00	05700 CT SCAN	0.047844	64,633	3,092	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.278342	7,999	2,226	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.360348	2,278	821	59.00
60.00	06000 LABORATORY	0.638810	73,625	47,032	60.00
60.01	06001 ONCOLOGY	0.298231	592	177	60.01
60.02	06002 RADIATION ONCOLOGY	0.000000	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	0.418047	91,240	38,143	65.00
66.00	06600 PHYSICAL THERAPY	0.301213	2,208,644	665,272	66.00
69.00	06900 ELECTROCARDIOLOGY	0.190379	54,485	10,373	69.00
69.01	06901 CARDIAC REHAB	0.470144	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.163052	390,593	63,687	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.732454	88	64	90.00
91.00	09100 EMERGENCY	0.143828	93,652	13,470	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.434303	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		3,061,653	860,335	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)		3,061,653		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/25/2019 10:38 am	
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		944,198	30.00
31.00	03100	INTENSIVE CARE UNIT		211,768	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.169273	1,103,887	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.256973	71,695	54.00
57.00	05700	CT SCAN	0.047844	143,729	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.278342	4,797	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.360348	4,646	59.00
60.00	06000	LABORATORY	0.638810	122,910	60.00
60.01	06001	ONCOLOGY	0.298231	496	60.01
60.02	06002	RADIATION ONCOLOGY	0.000000	0	60.02
65.00	06500	RESPIRATORY THERAPY	0.418047	49,150	65.00
66.00	06600	PHYSICAL THERAPY	0.301213	35,638	66.00
69.00	06900	ELECTROCARDIOLOGY	0.190379	103,769	69.00
69.01	06901	CARDIAC REHAB	0.470144	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.163052	213,391	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.732454	0	90.00
91.00	09100	EMERGENCY	0.143828	321,944	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.434303	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,176,052	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)		2,176,052	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0011 Component CCN: 15-T011	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/25/2019 10:38 am	
		Title XIX	Subprovider - IRF	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
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		34,479	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.169273	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.256973	566	54.00
57.00	05700	CT SCAN	0.047844	1,020	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.278342	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.360348	0	59.00
60.00	06000	LABORATORY	0.638810	459	60.00
60.01	06001	ONCOLOGY	0.298231	0	60.01
60.02	06002	RADIATION ONCOLOGY	0.000000	0	60.02
65.00	06500	RESPIRATORY THERAPY	0.418047	2,957	65.00
66.00	06600	PHYSICAL THERAPY	0.301213	27,090	66.00
69.00	06900	ELECTROCARDIOLOGY	0.190379	239	69.00
69.01	06901	CARDIAC REHAB	0.470144	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.163052	3,072	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.732454	0	90.00
91.00	09100	EMERGENCY	0.143828	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.434303	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		35,403	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)		35,403	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prepared: 11/25/2019 10:38 am
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		3,508,863	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		10,128,960	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)		96,288	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		96.52	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.15	30.00
31.00	Percentage of Medicaid patient days (see instructions)		26.33	31.00
32.00	Sum of lines 30 and 31		31.48	32.00
33.00	Allowable disproportionate share percentage (see instructions)		15.19	33.00
34.00	Disproportionate share adjustment (see instructions)		517,896	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prepared: 11/25/2019 10:38 am
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	6,766,695,164	8,272,872,447	35.00
35.01	Factor 3 (see instructions)	0.000205554	0.000277059	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,390,921	2,292,076	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	350,589	1,714,347	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,064,936		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	16,316,943		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	14,818,881		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		16,316,943	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,135,536	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		17,452,479	59.00
60.00	Primary payer payments		29,397	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		17,423,082	61.00
62.00	Deductibles billed to program beneficiaries		1,860,780	62.00
63.00	Coinsurance billed to program beneficiaries		22,924	63.00
64.00	Allowable bad debts (see instructions)		165,701	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		107,706	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		20,591	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		15,647,084	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		66,716	70.93
70.94	HRR adjustment amount (see instructions)		-10,519	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prepared: 11/25/2019 10:38 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0		0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			175,087	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			15,528,194	71.00
71.01	Sequestration adjustment (see instructions)			310,564	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
72.00	Interim payments			15,410,909	72.00
73.00	Tentative settlement (for contractor use only)			0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)			-193,279	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			271,483	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/25/2019 10:38 am

		Title XVIII			Hospital		PPS	
	W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)		
	0	1.00	2.00	3.00	4.00	5.00		
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,508,863	0	3,508,863		3,508,863	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	10,128,960	0		10,128,960	10,128,960	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	96,288	0	0	96,288	96,288	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1519	0.1519	0.1519	0.1519		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	517,896	0	133,249	384,647	517,896	11.00
11.01	Uncompensated care payments	36.00	2,064,936	0	350,589	1,714,347	2,064,936	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	16,316,943	0	3,992,701	12,324,242	16,316,943	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	16,316,943	0	3,992,701	12,324,242	16,316,943	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,135,536	0	295,904	839,632	1,135,536	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/25/2019 10:38 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	4,288,605	13,163,874	17,452,479	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,109,867	0	285,734	824,133	1,109,867	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	25,669	0	10,170	15,499	25,669	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,135,536	0	295,904	839,632	1,135,536	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/25/2019 10:38 am
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		Title XVIII			Hospital	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,508,863	3,508,863		3,508,863	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	10,128,960		10,128,960	10,128,960	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	96,288	0	96,288	96,288	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1519	0.1519	0.1519		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	517,896	133,249	384,647	517,896	11.00
11.01	Uncompensated care payments	36.00	2,064,936	350,589	1,714,347	2,064,936	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	16,316,943	3,992,701	12,324,242	16,316,943	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	16,316,943	3,992,701	12,324,242	16,316,943	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,135,536	295,904	839,632	1,135,536	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			4,288,605	13,163,874	17,452,479	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/25/2019 10:38 am
Title XVIII			Hospital	PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,109,867	285,734	824,133	1,109,867	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	25,669	10,170	15,499	25,669	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,135,536	295,904	839,632	1,135,536	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00		70.96	0	0		0	27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0	0	0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0			0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	66,716	6,408	60,308	66,716	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-10,519	-1,404	-9,115	-10,519	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		42,936	132,151	175,087	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 11/25/2019 10:38 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		1,242	1.00
2.00	Medical and other services reimbursed under OPPTS (see instructions)		20,129,240	2.00
3.00	OPPTS payments		18,961,698	3.00
4.00	Outlier payment (see instructions)		134,761	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)		1,242	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		7,222	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)		7,222	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 charge basis 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)		7,222	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		5,980	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)		1,242	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)		19,096,459	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		3,710,870	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)		15,386,831	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)		15,386,831	30.00
31.00	Primary payer payments		2,681	31.00
32.00	Subtotal (line 30 minus line 31)		15,384,150	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)		794,394	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		516,356	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		511,880	36.00
37.00	Subtotal (see instructions)		15,900,506	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-181	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)		15,900,687	40.00
40.01	Sequestration adjustment (see instructions)		318,014	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		15,659,562	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-76,889	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 15-0011		Period: From 07/01/2018 To 06/30/2019		Worksheet E-1 Part I Date/Time Prepared: 11/25/2019 10:38 am	
		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		15,228,950		15,076,097	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	07/24/2019	119,459	07/24/2019	583,465		3.01
3.02		01/15/2019	62,500		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		181,959		583,465		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)		15,410,909		15,659,562		4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		0		6.01
6.02	SETTLEMENT TO PROGRAM		193,279		76,889		6.02
7.00	Total Medicare program liability (see instructions)		15,217,630		15,582,673		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: 15-0011
Component CCN: 15-T011

Period:
From 07/01/2018
To 06/30/2019

Worksheet E-1
Part I
Date/Time Prepared:
11/25/2019 10:38 am
PPS

Title XVIII

Subprovider -
IRF

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		3,735,242		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,735,242		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		36,076		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,771,318		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: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet E-1 Part II Date/Time Prepared: 11/25/2019 10:38 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0011 Component CCN: 15-T011	Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part III Date/Time Prepared: 11/25/2019 10:38 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			3,735,919 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0217 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			123,285 3.00
4.00	Outlier Payments			44,500 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			7.728767 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			3,903,704 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			3,903,704 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			3,903,704 19.00
20.00	Deductibles			55,420 20.00
21.00	Subtotal (line 19 minus line 20)			3,848,284 21.00
22.00	Coinurance			0 22.00
23.00	Subtotal (line 21 minus line 22)			3,848,284 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			0 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			3,848,284 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			3,848,284 32.00
32.01	Sequestration adjustment (see instructions)			76,966 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			3,735,242 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			36,076 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			44,500 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part VII Date/Time Prepared: 11/25/2019 10:38 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		1,167,434		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		1,167,434	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		1,167,434	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		1,155,966		8.00
9.00	Ancillary service charges		2,176,052	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		3,332,018	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		3,332,018	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		2,164,584	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		1,167,434	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		1,167,434	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		1,167,434	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		1,167,434	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		1,167,434	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		1,167,434	0	40.00
41.00	Interim payments		1,566,048	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-398,614	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0011 Component CCN: 15-T011	Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part VII Date/Time Prepared: 11/25/2019 10:38 am
		Title XIX	Subprovider - IRF	Cost
		Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	238,739		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	238,739	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	238,739	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	35,403	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	35,403	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	35,403	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	203,336	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	35,403	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	35,403	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	203,336	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	35,403	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	35,403	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	35,403	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	35,403	0	40.00
41.00	Interim payments	16,073	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	19,330	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet G

Date/Time Prepared:
11/25/2019 10:38 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	8,145,245	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	61,281,442	0	0	0	4.00
5.00	Other receivable	3,649,512	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-37,731,576	0	0	0	6.00
7.00	Inventory	2,052,978	0	0	0	7.00
8.00	Prepaid expenses	3,064,771	0	0	0	8.00
9.00	Other current assets	926,265	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)	41,388,637	0	0	0	11.00
FIXED ASSETS						
12.00	Land	5,191,829	0	0	0	12.00
13.00	Land improvements	3,353,531	0	0	0	13.00
14.00	Accumulated depreciation	-2,783,199	0	0	0	14.00
15.00	Buildings	139,652,632	0	0	0	15.00
16.00	Accumulated depreciation	-80,278,883	0	0	0	16.00
17.00	Leasehold improvements	3,551,213	0	0	0	17.00
18.00	Accumulated depreciation	-2,554,854	0	0	0	18.00
19.00	Fixed equipment	3,509,530	0	0	0	19.00
20.00	Accumulated depreciation	-974,767	0	0	0	20.00
21.00	Automobiles and trucks	1,030,564	0	0	0	21.00
22.00	Accumulated depreciation	-902,041	0	0	0	22.00
23.00	Major movable equipment	70,915,959	0	0	0	23.00
24.00	Accumulated depreciation	-57,698,318	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	791,164	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	82,804,360	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	255,286,446	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	9,715,680	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	265,002,126	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	389,195,123	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	5,196,908	0	0	0	37.00
38.00	Salaries, wages, and fees payable	6,172,851	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3,192,733	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	14,562,492	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	81,183,555	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	81,183,555	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	95,746,047	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	293,449,076				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	293,449,076	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	389,195,123	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet G-1

Date/Time Prepared:
11/25/2019 10:38 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		282,727,185		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		10,721,891				2.00
3.00	Total (sum of line 1 and line 2)		293,449,076		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		293,449,076		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		293,449,076		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/25/2019 10:38 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	18,661,744		18,661,744	1.00
2.00	SUBPROVIDER - IPF	3,619,018		3,619,018	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	22,280,762		22,280,762	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	6,914,647		6,914,647	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	6,914,647		6,914,647	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	29,195,409		29,195,409	17.00
18.00	Ancillary services	81,907,647		81,907,647	18.00
19.00	Outpatient services	0	351,357,654	351,357,654	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	4,437,465	4,437,465	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PRACTICE	0	53,940,292	53,940,292	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	111,103,056	409,735,411	520,838,467	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		185,946,618		29.00
30.00	ELIMINATIONS	-1,088,525			30.00
31.00	BAD DEBT ADJUSTMENT	-655,111			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)		-1,743,636		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)		184,202,982		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0011

Period:
From 07/01/2018
To 06/30/2019

Worksheet G-3

Date/Time Prepared:
11/25/2019 10:38 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	520,838,467	1.00
2.00	Less contractual allowances and discounts on patients' accounts	340,836,766	2.00
3.00	Net patient revenues (line 1 minus line 2)	180,001,701	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	184,202,982	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,201,281	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	13,079,283	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	1,879,944	24.00
25.00	Total other income (sum of lines 6-24)	14,959,227	25.00
26.00	Total (line 5 plus line 25)	10,757,946	26.00
27.00	BAD DEBT EXPENSE	36,055	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	36,055	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	10,721,891	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0011	Period: From 07/01/2018 To 06/30/2019	Worksheet L Parts I-III Date/Time Prepared: 11/25/2019 10:38 am
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,109,867	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		25,669	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		47.68	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		1,135,536	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00