

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED
OMB NO. 0938-0050
EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 7/13/2020 7:28 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report 2. <input type="checkbox"/> Manually prepared cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: _____ Time: _____
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: _____ 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ALTON MEMORIAL HOSPITAL (14-0002) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 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	-34,735	-146,167	0	0	1.00
2.00 Subprovider - IPF	0	17,614	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing Bed - SNF	0	0	0		0	5.00
6.00 Swing Bed - NF	0	0	0		0	6.00
200.00 Total	0	-17,121	-146,167	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0002		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 7/13/2020 7:28 am				
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 State: IL		4.00 Zip Code: 62002- County: MADISON				
1.00 Street: ONE MEMORIAL DRIVE		2.00 City: ALTON								
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		
3.00 Hospital and Hospital-Based Component Identification:										
3.00	Hospital	ALTON MEMORIAL HOSPITAL	140002	41180	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF	ALTON MEMORIAL HOSPITAL PSYCH	14S002	41180	4	01/01/2008	N	P	N	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									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)				01/01/2019		12/31/2019		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)			Y	Y				22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.			N	N				22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.			N	N	N			22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.				N	3			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.			870	544	26	24	2,654	466	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0002		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 7/13/2020 7:28 am			
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	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.					1		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00	
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00	
						V	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	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR 412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					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 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.			N				60.00	

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet S-2
Part I
Date/Time Prepared:
7/13/2020 7:28 am

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

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			1.00			
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	80.00		
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N	81.00		
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N	85.00		
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00		
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.00		
			V 1.00	XIX 2.00		
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00		
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00		
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		Y	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. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01		
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02		
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03		
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04		
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05		
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06		
Rural Providers						
105.00	Does this hospital qualify as a CAH?	N		105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00		
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00		
			Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 7/13/2020 7:28 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	0	692,500	1,772,000
		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	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB1804	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 7/13/2020 7:28 am	
1.00		2.00		3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name: BJC HEALTH SYSTEM	Contractor's Name: WPS		Contractor's Number: 05301	
142.00	Street: 4901 FOREST PARK AVENUE	PO Box:			
143.00	City: ST. LOUIS	State: MO		Zip Code: 63108	
144.00 Are provider based physicians' costs included in Worksheet A?					
				1.00	2.00
				Y	
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.					
				1.00	2.00
				Y	
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.					
				1.00	2.00
				N	
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					
				1.00	2.00
				N	
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					
				1.00	2.00
				N	
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					
				1.00	2.00
				N	
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)					
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
155.00	Hospital	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N
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.					
				1.00	2.00
				N	
		Name	County	State	Zip Code
		0	1.00	2.00	3.00
		4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)				
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.					
				1.00	2.00
				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)					
				1.00	2.00
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					
				1.00	2.00
				N	
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)					
				1.00	2.00
					0.00
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					
				1.00	2.00
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					
				1.00	2.00
				N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0002		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part II Date/Time Prepared: 7/13/2020 7:28 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	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.				Y		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N		14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				N		15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	03/23/2020	Y	03/23/2020		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		Y			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 7/13/2020 7:28 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		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		Y		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		Y		35.00
					Y/N
					Date
					1.00
					2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
					1.00
					2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PAUL		BRADSHAW	41.00
42.00	Enter the employer/company name of the cost report preparer.	BJC HEALTHCARE			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-362-7419		PJB1541@BJC.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 7/13/2020 7:28 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.	REIMBURSEMENT 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

HFS Supplemental Information		Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part IX Date/Time Prepared: 7/13/2020 7:28 am
		Title V 1.00	Title XIX 2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.01)	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.02)	Y	Y	3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?	N	N	3.01
		Inpatient 1.00	Outpatient 2.00	
CRITICAL ACCESS HOSPITALS				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	5.00
		Title V 1.00	Title XIX 2.00	
RCE DISALLOWANCE				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.05)	Y	Y	6.00
PASS THROUGH COST				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.06)	Y	Y	7.00
RHC				
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	8.00
FQHC				
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	9.00
		State 1.00		
STATE MEDICAID FORMS				
10.00	Select the state when using state Medicaid forms.			10.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet S-3
Part I
Date/Time Prepared:
7/13/2020 7:28 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	96	36,040	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)		96	36,040	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,380	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		108	40,420	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	20	7,300		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		128				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet S-3
Part I
Date/Time Prepared:
7/13/2020 7:28 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	9,849	805	21,994			1.00
2.00 HMO and other (see instructions)	5,462	3,442				2.00
3.00 HMO IPF Subprovider	239	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	9,849	805	21,994			7.00
8.00 INTENSIVE CARE UNIT	1,147	117	2,283			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		220	1,689			13.00
14.00 Total (see instructions)	10,996	1,142	25,966	0.00	698.90	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	1,649	0	2,112	0.00	14.80	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)			0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	713.70	27.00
28.00 Observation Bed Days		0	1,074			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00
33.01 LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet S-3
Part I
Date/Time Prepared:
7/13/2020 7:28 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	2,563	419	7,672	1.00
2.00 HMO and other (see instructions)				1,394	0		2.00
3.00 HMO IPF Subprovider					0		3.00
4.00 HMO IRF Subprovider					0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0		2,563	419	7,672	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF	0.00	0		128	0	176	16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days				0			33.00
33.01 LTCH site neutral days and discharges				0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet S-3
Part II
Date/Time Prepared:
7/13/2020 7:28 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	47,542,176	0	47,542,176	1,475,371.00	32.22
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		81,796	0	81,796	689.00	118.72
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FOHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		6,233,434	22,510	6,255,944	173,026.00	36.16
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		855,282	0	855,282	11,786.00	72.57
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		295,287	0	295,287	2,875.00	102.71
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		7,657,515	0	7,657,515	181,975.00	42.08
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		12,122,485	0	12,122,485		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,142,064	0	1,142,064		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		21,822	0	21,822		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FOHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		1,376,019	0	1,376,019		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet S-3
Part II
Date/Time Prepared:
7/13/2020 7:28 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	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)	0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	1,490,779	0	1,490,779	78,042.00	19.10	26.00
27.00	Administrative & General	3,257,284	0	3,257,284	78,366.00	41.57	27.00
28.00	Administrative & General under contract (see inst.)	992,624	0	992,624	10,164.00	97.66	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	1,017,207	0	1,017,207	33,652.00	30.23	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	1,186,693	0	1,186,693	78,026.00	15.21	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)	563,057	0	563,057	21,098.00	26.69	35.00
36.00	Cafeteria	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	790,804	0	790,804	21,999.00	35.95	38.00
39.00	Central Services and Supply	211,128	0	211,128	11,653.00	18.12	39.00
40.00	Pharmacy	1,927,730	0	1,927,730	42,442.00	45.42	40.00
41.00	Medical Records & Medical Records Library	0	0	0	0.00	0.00	41.00
42.00	Social Service	1,106,122	0	1,106,122	31,857.00	34.72	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet S-3
Part III
Date/Time Prepared:
7/13/2020 7:28 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	49,097,857	0	49,097,857	1,506,633.00	32.59	1.00
2.00	Excluded area salaries (see instructions)	6,233,434	22,510	6,255,944	173,026.00	36.16	2.00
3.00	Subtotal salaries (line 1 minus line 2)	42,864,423	-22,510	42,841,913	1,333,607.00	32.12	3.00
4.00	Subtotal other wages & related costs (see inst.)	8,808,084	0	8,808,084	196,636.00	44.79	4.00
5.00	Subtotal wage-related costs (see inst.)	13,520,326	0	13,520,326	0.00	31.56	5.00
6.00	Total (sum of lines 3 thru 5)	65,192,833	-22,510	65,170,323	1,530,243.00	42.59	6.00
7.00	Total overhead cost (see instructions)	12,543,428	0	12,543,428	407,299.00	30.80	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet S-3 Part IV Date/Time Prepared: 7/13/2020 7:28 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			2,087,083 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			986,038 4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			0 8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)			0 8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)			5,225,776 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			219,621 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			32,155 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)			596,957 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			597,663 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			3,277,819 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			25,305 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			237,954 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			13,286,371 24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet S-3 Part V Date/Time Prepared: 7/13/2020 7:28 am
Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	866,282	13,286,371	1.00
2.00	Hospital	866,282	13,286,371	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet S-10 Date/Time Prepared: 7/13/2020 7:28 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)		0.226179	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		6,960,606	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		1,995,455	5.00	
6.00	Medicaid charges		68,126,453	6.00	
7.00	Medicaid cost (line 1 times line 6)		15,408,773	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		6,452,712	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		165,368	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		6,452,712	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)	10,310,834	2,096,489	12,407,323	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,332,094	2,096,489	4,428,583	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,332,094	2,096,489	4,428,583	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)		9,185,936	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		721,745	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1,110,377	27.01	
28.00	Non-Medicare bad debt expense (see instructions)		8,075,559	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		2,215,154	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		6,643,737	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		13,096,449	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet A
Date/Time Prepared:
7/13/2020 7:28 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (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		0	0	4,997,766	4,997,766	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	6,368,862	6,368,862	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	306,351	774,964	1,081,315	-1,908	1,079,407	4.00
4.03	00401	ADMINISTRATIVE	1,184,428	385,966	1,570,394	-4,667	1,565,727	4.03
5.00	00500	ADMINISTRATIVE & GENERAL	3,257,284	38,396,125	41,653,409	-8,436,530	33,216,879	5.00
7.00	00700	OPERATION OF PLANT	1,017,207	2,551,738	3,568,945	-45,522	3,523,423	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	361,058	361,058	-262	360,796	8.00
9.00	00900	HOUSEKEEPING	1,186,693	621,312	1,808,005	-5,453	1,802,552	9.00
10.00	01000	DIETARY	0	2,803,610	2,803,610	-21,384	2,782,226	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	790,804	329,894	1,120,698	-52,725	1,067,973	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	211,128	478,555	689,683	-84,463	605,220	14.00
15.00	01500	PHARMACY	1,927,730	10,665,679	12,593,409	-309,600	12,283,809	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	-8,530	-8,530	8,535	5	16.00
17.00	01700	SOCIAL SERVICE	1,106,122	710,962	1,817,084	-1,195	1,815,889	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,676,386	7,324,274	18,000,660	-1,529,052	16,471,608	30.00
31.00	03100	INTENSIVE CARE UNIT	2,091,760	1,095,198	3,186,958	-102,436	3,084,522	31.00
40.00	04000	SUBPROVIDER - IPF	1,232,493	455,153	1,687,646	-7,017	1,680,629	40.00
43.00	04300	NURSERY	0	0	0	1,023,526	1,023,526	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,920,202	12,284,523	15,204,725	-7,880,060	7,324,665	50.00
51.00	05100	RECOVERY ROOM	482,876	359,876	842,752	-110,616	732,136	51.00
53.00	05300	ANESTHESIOLOGY	35,184	246,549	281,733	-27,439	254,294	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,188,936	2,143,478	4,332,414	-771,529	3,560,885	54.00
56.00	05600	RADIOISOTOPE	207,031	331,091	538,122	-69,388	468,734	56.00
57.00	05700	CT SCAN	246,730	528,740	775,470	-218,538	556,932	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	462,533	893,779	1,356,312	-71,261	1,285,051	58.00
59.00	05900	CARDIAC CATHETERIZATION	697,446	2,156,948	2,854,394	-1,679,145	1,175,249	59.00
60.00	06000	LABORATORY	1,378,605	3,125,756	4,504,361	-557,351	3,947,010	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	223,587	627,412	850,999	264,772	1,115,771	63.00
65.00	06500	RESPIRATORY THERAPY	1,077,212	569,597	1,646,809	-62,028	1,584,781	65.00
66.00	06600	PHYSICAL THERAPY	1,299,792	544,584	1,844,376	-49,178	1,795,198	66.00
67.00	06700	OCCUPATIONAL THERAPY	304,185	75,539	379,724	14,957	394,681	67.00
68.00	06800	SPEECH PATHOLOGY	219,313	66,907	286,220	14,361	300,581	68.00
69.00	06900	ELECTROCARDIOLOGY	801,454	470,939	1,272,393	28,680	1,301,073	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,214,117	3,214,117	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	6,860,150	6,860,150	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	436,123	436,123	-12,063	424,060	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	892,340	2,011,985	2,904,325	-79,794	2,824,531	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	717,899	706,060	1,423,959	-62,842	1,361,117	76.01
76.02	03550	OP PSYCH	288,056	125,468	413,524	-1,923	411,601	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	203,561	203,561	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	3,109,468	1,604,004	4,713,472	-312,605	4,400,867	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	2,136,117	1,576,480	3,712,597	-429,587	3,283,010	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44,677,352	97,831,796	142,509,148	1,726	142,510,874	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	31,181	-540,290	-509,109	-417	-509,526	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0	192.01
192.02	19202	PHYSICIAN PRACTICES	1,956,147	5,903,762	7,859,909	0	7,859,909	192.02
193.00	19300	NONPAID WORKERS	9,460	3,529	12,989	0	12,989	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	181,117	614,535	795,652	-531	795,121	193.01
193.02	19302	MEDICAL OFFICE BUILDING	228,983	529,243	758,226	0	758,226	193.02
193.03	19303	HOME CARE PHARMACY	304,202	1,209,011	1,513,213	-778	1,512,435	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	0	0	0	193.05
193.06	19306	VACANT SPACE	0	0	0	0	0	193.06
193.07	19307	POB 2	153,734	559,773	713,507	0	713,507	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	0	0	0	193.08
193.09	19309	COFFEE BAR	0	48,008	48,008	0	48,008	193.09
200.00		TOTAL (SUM OF LINES 118 through 199)	47,542,176	106,159,367	153,701,543	0	153,701,543	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet A
Date/Time Prepared:
7/13/2020 7:28 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	0	4,997,766	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-38,238	6,330,624	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	150,560	1,229,967	4.00
4.03	00401	ADMINISTRATIVE	0	1,565,727	4.03
5.00	00500	ADMINISTRATIVE & GENERAL	-6,693,368	26,523,511	5.00
7.00	00700	OPERATION OF PLANT	-30,540	3,492,883	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	360,796	8.00
9.00	00900	HOUSEKEEPING	0	1,802,552	9.00
10.00	01000	DIETARY	529,222	3,311,448	10.00
11.00	01100	CAFETERIA	-494,847	-494,847	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,067,973	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	605,220	14.00
15.00	01500	PHARMACY	0	12,283,809	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5	16.00
17.00	01700	SOCIAL SERVICE	0	1,815,889	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,842,005	13,629,603	30.00
31.00	03100	INTENSIVE CARE UNIT	-241,992	2,842,530	31.00
40.00	04000	SUBPROVIDER - IPF	-54,054	1,626,575	40.00
43.00	04300	NURSERY	0	1,023,526	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-116,714	7,207,951	50.00
51.00	05100	RECOVERY ROOM	0	732,136	51.00
53.00	05300	ANESTHESIOLOGY	0	254,294	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-280,597	3,280,288	54.00
56.00	05600	RADIOISOTOPE	0	468,734	56.00
57.00	05700	CT SCAN	0	556,932	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-632,665	652,386	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,175,249	59.00
60.00	06000	LABORATORY	218,881	4,165,891	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,115,771	63.00
65.00	06500	RESPIRATORY THERAPY	0	1,584,781	65.00
66.00	06600	PHYSICAL THERAPY	-30	1,795,168	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	394,681	67.00
68.00	06800	SPEECH PATHOLOGY	-178	300,403	68.00
69.00	06900	ELECTROCARDIOLOGY	-26,591	1,274,482	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,214,117	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	6,860,150	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	424,060	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	-1,393,498	1,431,033	76.00
76.01	03340	GASTROINTESTINAL SERVICES	0	1,361,117	76.01
76.02	03550	OP PSYCH	0	411,601	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	203,561	76.98
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-25	4,400,842	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-20,284	3,262,726	95.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-11,966,963	130,543,911	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	-509,526	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	192.01
192.02	19202	PHYSICIAN PRACTICES	0	7,859,909	192.02
193.00	19300	NONPAID WORKERS	0	12,989	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	0	795,121	193.01
193.02	19302	MEDICAL OFFICE BUILDING	0	758,226	193.02
193.03	19303	HOME CARE PHARMACY	0	1,512,435	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	193.05
193.06	19306	VACANT SPACE	0	0	193.06
193.07	19307	POB 2	0	713,507	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	193.08
193.09	19309	COFFEE BAR	0	48,008	193.09
200.00		TOTAL (SUM OF LINES 118 through 199)	-11,966,963	141,734,580	200.00

COST CENTERS USED IN COST REPORT		Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet Non-CMS W
		Date/Time Prepared: 7/13/2020 7:28 am		
Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAPITAL RELATED COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
4.03	ADMINISTRATIVE	00401		4.03
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
40.00	SUBPROVIDER - IPF	04000		40.00
43.00	NURSERY	04300		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
56.00	RADIOISOTOPE	05600		56.00
57.00	CT SCAN	05700		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
59.00	CARDIAC CATHETERIZATION	05900		59.00
60.00	LABORATORY	06000		60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	06300		63.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
74.00	RENAL DIALYSIS	07400		74.00
76.00	ONCOLOGY & PAIN MANAGEMENT	03020	ACUPUNCTURE	76.00
76.01	GASTRO INTESTINAL SERVICES	03340	GASTRO INTESTINAL SERVICES	76.01
76.02	OP PSYCH	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.02
76.98	HYPERBARIC OXYGEN THERAPY	07698	HYPERBARIC OXYGEN THERAPY	76.98
OUTPATIENT SERVICE COST CENTERS				
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	09500		95.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
192.01	TWIN RIVERS MRI	19201		192.01
192.02	PHYSICIAN PRACTICES	19202		192.02
193.00	NONPAID WORKERS	19300		193.00
193.01	PHYSICIAN/PUBLIC RELATIONS	19301		193.01
193.02	MEDICAL OFFICE BUILDING	19302		193.02
193.03	HOME CARE PHARMACY	19303		193.03
193.04	MANAGEMENT SERVICES	19304		193.04
193.05	EUNICE SMITH NURSING HOME	19305		193.05
193.06	VACANT SPACE	19306		193.06
193.07	POB 2	19307		193.07
193.08	NON REIMBURSABLE MEALS	19308		193.08
193.09	COFFEE BAR	19309		193.09
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

RECLASSIFICATIONS

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-6

Date/Time Prepared:
7/13/2020 7:28 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - RECLASS DEPRECIATION					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	4,886,189	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	6,316,129	2.00
			0	11,202,318	
B - RECLASS MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	10,074,267	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
			0	10,074,267	
C - TO RECLASS LAB ADMIN					
1.00	BLOOD STORING, PROCESSING & TRANS.	63.00	81,515	187,444	1.00
			81,515	187,444	
D - TO RECLASS DIRECTOR'S EXPENSE					
1.00	RECOVERY ROOM	51.00	26,906	2,058	1.00
2.00	ANESTHESIOLOGY	53.00	35,902	2,747	2.00
3.00	RADIOISOTOPE	56.00	4,399	337	3.00
4.00	OCCUPATIONAL THERAPY	67.00	18,323	1,402	4.00
5.00	SPEECH PATHOLOGY	68.00	14,377	1,100	5.00
6.00	ELECTROCARDIOLOGY	69.00	94,734	7,248	6.00
7.00	CT SCAN	57.00	34,242	2,620	7.00
8.00	GASTROINTESTINAL SERVICES	76.01	26,743	2,047	8.00
9.00	AMBULANCE SERVICES	95.00	22,510	1,722	9.00
10.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	9,175	702	10.00
			287,311	21,983	
E - TO RECLASS HYPERBARIC OXYGEN EXPENSE					
1.00	HYPERBARIC OXYGEN THERAPY	76.98	0	203,561	1.00
			0	203,561	
F - TO RECLASS DEPRECIATION DEPT EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,930,098	1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	8,535	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35.00
36.00		0.00	0	0		36.00
				2,938,633		
G - TO RECLASS PROPERTY INSURANCE						
1.00	OTHER CAPITAL RELATED COSTS	3.00	0	164,310		1.00
			0	164,310		
H - TO RECLASS MEDICAL IMPLANTS						
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	6,860,150		1.00
			0	6,860,150		
I - TO RECLASS NURSERY COSTS						
1.00	NURSERY	43.00	774,716	248,810		1.00
	TOTALS		774,716	248,810		
500.00	Grand Total: Increases		1,143,542	31,901,476		500.00

RECLASSIFICATIONS

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-6
Date/Time Prepared:
7/13/2020 7:28 am

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - RECLASS DEPRECIATION							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	11,202,318	9		1.00
2.00		0.00	0	0	9		2.00
	0		0	11,202,318			
B - RECLASS MEDICAL SUPPLIES							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	50,849	0		1.00
2.00	PHARMACY	15.00	0	305,410	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	349,260	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	79,546	0		4.00
5.00	SUBPROVIDER - IPF	40.00	0	4,696	0		5.00
6.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	293	0		6.00
7.00	OPERATING ROOM	50.00	0	7,171,793	0		7.00
8.00	RECOVERY ROOM	51.00	0	118,376	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	52,154	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	33,137	0		10.00
11.00	RADIOISOTOPE	56.00	0	771	0		11.00
12.00	CT SCAN	57.00	0	7,621	0		12.00
13.00	CARDIAC CATHETERIZATION	59.00	0	1,458,248	0		13.00
14.00	LABORATORY	60.00	0	484	0		14.00
15.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	105	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	1,870	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	5,249	0		17.00
18.00	OCCUPATIONAL THERAPY	67.00	0	2,707	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	0	7,230	0		19.00
20.00	RENAL DIALYSIS	74.00	0	12,063	0		20.00
21.00	ONCOLOGY & PAIN MANAGEMENT	76.00	0	29,981	0		21.00
22.00	GASTROINTESTINAL SERVICES	76.01	0	64,087	0		22.00
23.00	OP PSYCH	76.02	0	130	0		23.00
24.00	EMERGENCY	91.00	0	237,569	0		24.00
25.00	AMBULANCE SERVICES	95.00	0	79,522	0		25.00
26.00	SPEECH PATHOLOGY	68.00	0	1,116	0		26.00
	0		0	10,074,267			
C - TO RECLASS LAB ADMIN							
1.00	LABORATORY	60.00	81,515	187,444	0		1.00
	0		81,515	187,444			
D - TO RECLASS DIRECTOR'S EXPENSE							
1.00	OPERATING ROOM	50.00	89,551	6,852	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	47,816	3,659	0		2.00
3.00	RESPIRATORY THERAPY	65.00	41,778	3,197	0		3.00
4.00	PHYSICAL THERAPY	66.00	32,700	2,502	0		4.00
5.00	CARDIAC CATHETERIZATION	59.00	52,956	4,051	0		5.00
6.00	EMERGENCY	91.00	22,510	1,722	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
	0		287,311	21,983			
E - TO RECLASS HYPERBARIC OXYGEN EXPENSE							
1.00	OPERATING ROOM	50.00	0	203,561	0		1.00
	0		0	203,561			
F - TO RECLASS DEPRECIATION DEPT EXPENSE							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,908	0		1.00
2.00	ADMINISTRATIVE	4.03	0	4,667	0		2.00
3.00	OPERATION OF PLANT	7.00	0	45,522	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	262	0		4.00
5.00	HOUSEKEEPING	9.00	0	5,453	0		5.00
6.00	DIETARY	10.00	0	21,384	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	52,725	0		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	33,614	0		8.00
9.00	PHARMACY	15.00	0	4,190	0		9.00
11.00	SOCIAL SERVICE	17.00	0	1,195	0		11.00
12.00	ADULTS & PEDIATRICS	30.00	0	156,266	0		12.00
13.00	INTENSIVE CARE UNIT	31.00	0	22,890	0		13.00
14.00	SUBPROVIDER - IPF	40.00	0	2,321	0		14.00
15.00	OPERATING ROOM	50.00	0	408,303	0		15.00
16.00	RECOVERY ROOM	51.00	0	21,204	0		16.00
17.00	ANESTHESIOLOGY	53.00	0	13,934	0		17.00
18.00	RADIOLOGY-DIAGNOSTIC	54.00	0	686,917	0		18.00
19.00	RADIOISOTOPE	56.00	0	73,353	0		19.00
20.00	CT SCAN	57.00	0	247,779	0		20.00
21.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	80,845	0		21.00

RECLASSIFICATIONS

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-6

Date/Time Prepared:
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Decreases								
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
22.00	CARDIAC CATHETERIZATION	59.00	0	163,890	0		22.00	
23.00	LABORATORY	60.00	0	287,908	0		23.00	
24.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	4,082	0		24.00	
25.00	RESPIRATORY THERAPY	65.00	0	15,183	0		25.00	
26.00	PHYSICAL THERAPY	66.00	0	8,727	0		26.00	
27.00	OCCUPATIONAL THERAPY	67.00	0	2,061	0		27.00	
28.00	ELECTROCARDIOLOGY	69.00	0	66,072	0		28.00	
29.00	ONCOLOGY & PAIN MANAGEMENT	76.00	0	49,813	0		29.00	
30.00	GASTRO INTESTINAL SERVICES	76.01	0	27,545	0		30.00	
31.00	OP PSYCH	76.02	0	1,793	0		31.00	
32.00	EMERGENCY	91.00	0	50,804	0		32.00	
33.00	AMBULANCE SERVICES	95.00	0	374,297	0		33.00	
34.00	GI FT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	417	0		34.00	
35.00	PHYSICIAN/PUBLIC RELATIONS	193.01	0	531	0		35.00	
36.00	HOME CARE PHARMACY	193.03	0	778	0		36.00	
			0	2,938,633				
G - TO RECLASS PROPERTY INSURANCE								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	164,310	12		1.00	
			0	164,310				
H - TO RECLASS MEDICAL IMPLANTS								
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	6,860,150	0		1.00	
			0	6,860,150				
I - TO RECLASS NURSERY COSTS								
1.00	ADULTS & PEDIATRICS	30.00	774,716	248,810	0		1.00	
	TOTALS		774,716	248,810				
500.00	Grand Total: Decreases		1,143,542	31,901,476			500.00	

RECLASSIFICATIONS

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
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Increases					Decreases				
Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00		
A - RECLASS DEPRECIATION									
1.00	NEW CAP REL	1.00	0	4,886,189	ADMINISTRATIVE & GENERAL	5.00	0	11,202,318	1.00
2.00	COSTS-BLDG & FIXT	2.00	0	6,316,129		0.00	0	0	2.00
	NEW CAP REL								
	COSTS-MVBLE EQUIP		0	11,202,318			0	11,202,318	
B - RECLASS MEDICAL SUPPLIES									
1.00	MEDICAL SUPPLIES	71.00	0	10,074,267	CENTRAL SERVICES & SUPPLY	14.00	0	50,849	1.00
	CHARGED TO PATIENTS								
2.00		0.00	0	0	PHARMACY	15.00	0	305,410	2.00
3.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	349,260	3.00
4.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	79,546	4.00
5.00		0.00	0	0	SUBPROVIDER - I/PF	40.00	0	4,696	5.00
6.00		0.00	0	0	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	293	6.00
7.00		0.00	0	0	OPERATING ROOM	50.00	0	7,171,793	7.00
8.00		0.00	0	0	RECOVERY ROOM	51.00	0	118,376	8.00
9.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	52,154	9.00
10.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	33,137	10.00
11.00		0.00	0	0	RADIOISOTOPE	56.00	0	771	11.00
12.00		0.00	0	0	CT SCAN	57.00	0	7,621	12.00
13.00		0.00	0	0	CARDIAC CATHETERIZATION	59.00	0	1,458,248	13.00
14.00		0.00	0	0	LABORATORY	60.00	0	484	14.00
15.00		0.00	0	0	BLOOD STORAGE, PROCESSING & TRANS.	63.00	0	105	15.00
16.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	1,870	16.00
17.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	5,249	17.00
18.00		0.00	0	0	OCCUPATIONAL THERAPY	67.00	0	2,707	18.00
19.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	7,230	19.00
20.00		0.00	0	0	RENAL DIALYSIS	74.00	0	12,063	20.00
21.00		0.00	0	0	ONCOLOGY & PAIN MANAGEMENT	76.00	0	29,981	21.00
22.00		0.00	0	0	GASTROINTESTINAL SERVICES	76.01	0	64,087	22.00
23.00		0.00	0	0	OP PSYCH	76.02	0	130	23.00
24.00		0.00	0	0	EMERGENCY	91.00	0	237,569	24.00
25.00		0.00	0	0	AMBULANCE SERVICES	95.00	0	79,522	25.00
26.00		0.00	0	0	SPEECH PATHOLOGY	68.00	0	1,116	26.00
			0	10,074,267			0	10,074,267	
C - TO RECLASS LAB ADMIN									
1.00	BLOOD STORAGE, PROCESSING & TRANS.	63.00	81,515	187,444	LABORATORY	60.00	81,515	187,444	1.00
			81,515	187,444			81,515	187,444	
D - TO RECLASS DIRECTOR'S EXPENSE									
1.00	RECOVERY ROOM	51.00	26,906	2,058	OPERATING ROOM	50.00	89,551	6,852	1.00
2.00	ANESTHESIOLOGY	53.00	35,902	2,747	RADIOLOGY-DIAGNOSTIC	54.00	47,816	3,659	2.00
3.00	RADIOISOTOPE	56.00	4,399	337	RESPIRATORY THERAPY	65.00	41,778	3,197	3.00
4.00	OCCUPATIONAL THERAPY	67.00	18,323	1,402	PHYSICAL THERAPY	66.00	32,700	2,502	4.00
5.00	SPEECH PATHOLOGY	68.00	14,377	1,100	CARDIAC CATHETERIZATION	59.00	52,956	4,051	5.00
6.00	ELECTROCARDIOLOGY	69.00	94,734	7,248	EMERGENCY	91.00	22,510	1,722	6.00
7.00	CT SCAN	57.00	34,242	2,620		0.00	0	0	7.00
8.00	GASTROINTESTINAL SERVICES	76.01	26,743	2,047		0.00	0	0	8.00
9.00	AMBULANCE SERVICES	95.00	22,510	1,722		0.00	0	0	9.00
10.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	9,175	702		0.00	0	0	10.00
			287,311	21,983			287,311	21,983	
E - TO RECLASS HYPERBARIC OXYGEN EXPENSE									
1.00	HYPERBARIC OXYGEN THERAPY	76.98	0	203,561	OPERATING ROOM	50.00	0	203,561	1.00
			0	203,561			0	203,561	
F - TO RECLASS DEPRECIATION DEPT EXPENSE									
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,930,098	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,908	1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	8,535	ADMINISTRATIVE	4.03	0	4,667	2.00
3.00		0.00	0	0	OPERATION OF PLANT	7.00	0	45,522	3.00
4.00		0.00	0	0	LAUNDRY & LINEN SERVICE	8.00	0	262	4.00
5.00		0.00	0	0	HOUSEKEEPING	9.00	0	5,453	5.00
6.00		0.00	0	0	DIETARY	10.00	0	21,384	6.00
7.00		0.00	0	0	NURSING	13.00	0	52,725	7.00
					ADMINISTRATION				

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
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	Increases				Decreases					
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00		
8.00		0.00		0	0	CENTRAL SERVICES & SUPPLY	14.00	0	33,614	8.00
9.00		0.00		0	0	PHARMACY	15.00	0	4,190	9.00
11.00		0.00		0	0	SOCIAL SERVICE	17.00	0	1,195	11.00
12.00		0.00		0	0	ADULTS & PEDIATRICS	30.00	0	156,266	12.00
13.00		0.00		0	0	INTENSIVE CARE UNIT	31.00	0	22,890	13.00
14.00		0.00		0	0	SUBPROVIDER - IPF	40.00	0	2,321	14.00
15.00		0.00		0	0	OPERATING ROOM	50.00	0	408,303	15.00
16.00		0.00		0	0	RECOVERY ROOM	51.00	0	21,204	16.00
17.00		0.00		0	0	ANESTHESIOLOGY	53.00	0	13,934	17.00
18.00		0.00		0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	686,917	18.00
19.00		0.00		0	0	RADIOISOTOPE	56.00	0	73,353	19.00
20.00		0.00		0	0	CT SCAN	57.00	0	247,779	20.00
21.00		0.00		0	0	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	80,845	21.00
22.00		0.00		0	0	CARDIAC CATHETERIZATION	59.00	0	163,890	22.00
23.00		0.00		0	0	LABORATORY	60.00	0	287,908	23.00
24.00		0.00		0	0	BLOOD STORAGE, PROCESSING & TRANS.	63.00	0	4,082	24.00
25.00		0.00		0	0	RESPIRATORY THERAPY	65.00	0	15,183	25.00
26.00		0.00		0	0	PHYSICAL THERAPY	66.00	0	8,727	26.00
27.00		0.00		0	0	OCCUPATIONAL THERAPY	67.00	0	2,061	27.00
28.00		0.00		0	0	ELECTROCARDIOLOGY	69.00	0	66,072	28.00
29.00		0.00		0	0	ONCOLOGY & PAIN MANAGEMENT	76.00	0	49,813	29.00
30.00		0.00		0	0	GASTROINTESTINAL SERVICES	76.01	0	27,545	30.00
31.00		0.00		0	0	OP PSYCH	76.02	0	1,793	31.00
32.00		0.00		0	0	EMERGENCY	91.00	0	50,804	32.00
33.00		0.00		0	0	AMBULANCE SERVICES	95.00	0	374,297	33.00
34.00		0.00		0	0	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	417	34.00
35.00		0.00		0	0	PHYSICIAN/PUBLIC RELATIONS	193.01	0	531	35.00
36.00		0.00		0	0	HOME CARE PHARMACY	193.03	0	778	36.00
				0	2,938,633			0	2,938,633	
G - TO RECLASS PROPERTY INSURANCE										
1.00	OTHER CAPITAL RELATED COSTS	3.00		0	164,310	ADMINISTRATIVE & GENERAL	5.00	0	164,310	1.00
				0	164,310			0	164,310	
H - TO RECLASS MEDICAL IMPLANTS										
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00		0	6,860,150	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	6,860,150	1.00
				0	6,860,150			0	6,860,150	
I - TO RECLASS NURSERY COSTS										
1.00	NURSERY	43.00	774,716	248,810		ADULTS & PEDIATRICS	30.00	774,716	248,810	1.00
	TOTALS		774,716	248,810		TOTALS		774,716	248,810	
500.00	Grand Total: Increases		1,143,542	31,901,476		Grand Total: Decreases		1,143,542	31,901,476	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-7
Part I
Date/Time Prepared:
7/13/2020 7:28 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	177,168	0	0	0	1.00
2.00	Land Improvements	5,102,571	0	846,255	846,255	2.00
3.00	Buildings and Fixtures	104,494,021	0	3,179,868	3,179,868	3.00
4.00	Building Improvements	14,571,695	0	655,694	655,694	4.00
5.00	Fixed Equipment	1,036,531	0	49,500	49,500	5.00
6.00	Movable Equipment	50,148,417	0	6,730,755	6,730,755	6.00
7.00	HIT designated Assets	1,989,420	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	177,519,823	0	11,462,072	11,462,072	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	177,519,823	0	11,462,072	11,462,072	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	177,168	0			1.00
2.00	Land Improvements	5,948,826	0			2.00
3.00	Buildings and Fixtures	107,673,889	0			3.00
4.00	Building Improvements	15,227,389	0			4.00
5.00	Fixed Equipment	1,086,031	0			5.00
6.00	Movable Equipment	54,040,132	0			6.00
7.00	HIT designated Assets	1,989,420	0			7.00
8.00	Subtotal (sum of lines 1-7)	186,142,855	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	186,142,855	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-7
Part II
Date/Time Prepared:
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Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	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	0				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-7
Part III
Date/Time Prepared:
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Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	120,850,104	0	120,850,104	0.679064	111,577	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	57,115,583	0	57,115,583	0.320936	52,733	2.00
3.00	Total (sum of lines 1-2)	177,965,687	0	177,965,687	1.000000	164,310	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of col.s. 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	111,577	4,886,189	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	52,733	6,277,891	0	2.00
3.00	Total (sum of lines 1-2)	0	0	164,310	11,164,080	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of col.s. 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	0	111,577	0	0	4,997,766	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	52,733	0	0	6,330,624	2.00
3.00	Total (sum of lines 1-2)	0	164,310	0	0	11,328,390	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8

Date/Time Prepared:
7/13/2020 7:28 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
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			ONEW CAP REL COSTS-BLDG & FIXT	1.00		0 1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			ONEW CAP REL COSTS-MVBLE EQUIP	2.00		0 2.00
3.00 Investment income - other (chapter 2)		0		0.00		0 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00		0 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00		0 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00		0 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00		0 7.00
8.00 Television and radio service (chapter 21)	A	-484	OPERATION OF PLANT	7.00		0 8.00
9.00 Parking lot (chapter 21)		0		0.00		0 9.00
10.00 Provider-based physician adjustment	A-8-2	-6,085,470				0 10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00		0 11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-3,254,171				0 12.00
13.00 Laundry and linen service		0		0.00		0 13.00
14.00 Cafeteria-employees and guests	B	-494,847	CAFETERIA	11.00		0 14.00
15.00 Rental of quarters to employee and others		0		0.00		0 15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00		0 16.00
17.00 Sale of drugs to other than patients		0		0.00		0 17.00
18.00 Sale of medical records and abstracts		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		ORESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL 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			ONEW CAP REL COSTS-BLDG & FIXT	1.00		0 26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			ONEW CAP REL COSTS-MVBLE EQUIP	2.00		0 27.00
28.00 Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0	0.00		0 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			OADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		OSPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8

Date/Time Prepared:
7/13/2020 7:28 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	
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0 32.00
33.00 ASSOCIATION DUES	A	-29,335	ADMINISTRATIVE & GENERAL		5.00	0 33.00
33.01 OTHER REVENUE -MRI	A	-2,665	MAGNETIC RESONANCE IMAGING (MRI)		58.00	0 33.01
33.02 ELIMINATE FINANCING COSTS	A	-3,952	ADMINISTRATIVE & GENERAL		5.00	0 33.02
33.03 NON OPERATING DONATIONS	B	-86,017	ADMINISTRATIVE & GENERAL		5.00	0 33.03
33.04 OTHER NON OPERATING REVENUE	B	-5,594	ADMINISTRATIVE & GENERAL		5.00	0 33.04
33.05 MALPRACTICE EXPENSE	A	-1,772,000	ADMINISTRATIVE & GENERAL		5.00	0 33.05
33.06 ESH DIETARY COSTS	A	553,641	DIETARY		10.00	0 33.06
33.07 OTHER REVENUE - A&G	B	-392,665	ADMINISTRATIVE & GENERAL		5.00	0 33.07
33.08 OTHER REVENUE - PLANT OPERATIONS	B	-30,056	OPERATION OF PLANT		7.00	0 33.08
33.09 OTHER REVENUE - DIETARY	B	-24,419	DIETARY		10.00	0 33.09
33.10 ACCELERATED DEPRECIATION	B	-38,238	NEW CAP REL COSTS-MVBLE EQUIP		2.00	9 33.10
33.11 OTHER REVENUE EMERGENCY ROOM	B	-25	EMERGENCY		91.00	0 33.11
33.12 OTHER REVENUE- RADIOLOGY	B	-300	RADIOLOGY-DIAGNOSTIC		54.00	0 33.12
33.13 OTHER REVENUE - ONCOLOGY	B	-320	ONCOLOGY & PAIN MANAGEMENT		76.00	0 33.13
33.14 OTHER REVENUE - EKG	B	-26,571	ELECTROCARDIOLOGY		69.00	0 33.14
33.15 OTHER REVENUE - AMBULANCE	B	-20,284	AMBULANCE SERVICES		95.00	0 33.15
33.16 ABESTOS ABATEMENT	A	-34,594	ADMINISTRATIVE & GENERAL		5.00	0 33.16
33.17 PENSION EXPENSE	A	151,329	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.17
33.19 DISALLOWED INTEREST EXPENSE	A	-354,009	ADMINISTRATIVE & GENERAL		5.00	0 33.19
33.20 ALCOHOLIC BEVERAGES	A	-4,666	ADMINISTRATIVE & GENERAL		5.00	0 33.20
33.21 ALCOHOLIC BEVERAGES	A	-52	OPERATING ROOM		50.00	0 33.21
33.22 OTHER INCOME - SPEECH THERAPY	B	-178	SPEECH PATHOLOGY		68.00	0 33.22
33.23 ENTERTAINMENT EXPENSE	A	-54	SUBPROVIDER - IPF		40.00	9 33.23
33.24 ENTERTAINMENT EXPENSE	A	-769	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.24
33.25 ENTERTAINMENT EXPENSE	A	-4,567	ADMINISTRATIVE & GENERAL		5.00	0 33.25
33.26 ENTERTAINMENT EXPENSE	A	-10	OPERATING ROOM		50.00	0 33.26
33.27 ENTERTAINMENT EXPENSE	A	-30	PHYSICAL THERAPY		66.00	0 33.27
33.28 ENTERTAINMENT EXPENSE	A	-20	ELECTROCARDIOLOGY		69.00	0 33.28
33.29 NON ALLOWABLE EMPLOYEE ACTIVITIES	A	-5,571	ADMINISTRATIVE & GENERAL		5.00	0 33.29
33.30 OTHER ADJUSTMENTS (SPECIFY) (3)	A	0			0.00	0 33.30
33.31 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.31
33.32 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.32
33.33 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.33
33.34 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.34
33.35 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.35
34.00 OTHER ADJUSTMENTS (SPECIFY)		0			0.00	0 34.00
35.00 OTHER ADJUSTMENTS (SPECIFY)		0			0.00	0 35.00
36.00 OTHER ADJUSTMENTS (SPECIFY)		0			0.00	0 36.00
37.00 OTHER ADJUSTMENTS (SPECIFY)		0			0.00	0 37.00
38.00 OTHER ADJUSTMENTS (SPECIFY)		0			0.00	0 38.00
39.00 OTHER ADJUSTMENTS (SPECIFY)		0			0.00	0 39.00
40.00 OTHER ADJUSTMENTS (SPECIFY)		0			0.00	0 40.00
41.00 OTHER ADJUSTMENTS (SPECIFY)		0			0.00	0 41.00
42.00 OTHER ADJUSTMENTS (SPECIFY)		0			0.00	0 42.00
43.00 OTHER ADJUSTMENTS (SPECIFY)		0			0.00	0 43.00
44.00 OTHER ADJUSTMENTS (SPECIFY)		0			0.00	0 44.00
45.00 OTHER ADJUSTMENTS (SPECIFY)		0			0.00	0 45.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-11,966,963			0.00	50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8-1

Date/Time Prepared:
7/13/2020 7:28 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	BJC HEALTH SYSTEM	15,457,265	18,920,504 1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	CHRISTIAN HEALTH SERVICES	18,644	0 2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	TELEPHONE FACILITIES CORP	57,711	59,112 3.00
4.00	60.00	LABORATORY	BARNES JEWISH LAB	655,676	423,679 4.00
4.01	60.00	LABORATORY	CHILDREN'S HOSPITAL LAB	18,643	28,093 4.01
4.02	60.00	LABORATORY	MISSOURI BAPTIST HOSPITAL LA	17,010	20,676 4.02
4.03	50.00	OPERATING ROOM	MIDWEST SURGICAL TECHNOLOGIE	55,453	82,335 4.03
4.04	50.00	OPERATING ROOM	MIDWEST LITHOTRIPSY	20,301	20,475 4.04
5.00	0	0	0	16,300,703	19,554,874 5.00

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

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

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

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

6.00	G	BJC HEALTHCARE	100.00	0.00	6.00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or non-financial) specify:	HOME OFFICE			100.00

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

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

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

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8-1

Date/Time Prepared:
7/13/2020 7:28 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-3,463,239	0		1.00
2.00	18,644	0		2.00
3.00	-1,401	0		3.00
4.00	231,997	0		4.00
4.01	-9,450	0		4.01
4.02	-3,666	0		4.02
4.03	-26,882	0		4.03
4.04	-174	0		4.04
5.00	-3,254,171			5.00

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

Related Organization(s) and/or Home Office	Type of Business	
	6.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8-2

Date/Time Prepared:
7/13/2020 7:28 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	30.00	AGGREGATE-ADULTS & PEDIATRICS	245,544	245,544	0	0	0	1.00
2.00	30.00	DR. A	20,723	20,723	0	0	0	2.00
3.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	234,084	234,084	0	0	0	3.00
4.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	2,341,654	2,341,654	0	0	0	4.00
5.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	241,992	241,992	0	0	0	5.00
6.00	40.00	DR. B	54,000	54,000	0	0	0	6.00
7.00	50.00	AGGREGATE-OPERATING ROOM	89,596	89,596	0	0	0	7.00
8.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	280,297	280,297	0	0	0	8.00
9.00	58.00	AGGREGATE-MAGNETIC RESONANCE IMAGING	630,000	630,000	0	0	0	9.00
10.00	76.00	AGGREGATE-ONCOLOGY & PAIN MANAGEMENT	1,229,416	1,229,416	0	0	0	10.00
11.00	76.00	AGGREGATE-ONCOLOGY & PAIN MANAGEMENT	163,762	163,762	0	0	0	11.00
12.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	554,402	554,402	0	0	0	12.00
200.00			6,085,470	6,085,470	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	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	30.00	DR. A	0	0	0	0	0	2.00
3.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	4.00
5.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	0	0	5.00
6.00	40.00	DR. B	0	0	0	0	0	6.00
7.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	7.00
8.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	8.00
9.00	58.00	AGGREGATE-MAGNETIC RESONANCE IMAGING	0	0	0	0	0	9.00
10.00	76.00	AGGREGATE-ONCOLOGY & PAIN MANAGEMENT	0	0	0	0	0	10.00
11.00	76.00	AGGREGATE-ONCOLOGY & PAIN MANAGEMENT	0	0	0	0	0	11.00
12.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	0	0	12.00
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	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	245,544		1.00
2.00	30.00	DR. A	0	0	0	20,723		2.00
3.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	234,084		3.00
4.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	2,341,654		4.00
5.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	241,992		5.00
6.00	40.00	DR. B	0	0	0	54,000		6.00
7.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	89,596		7.00
8.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	280,297		8.00
9.00	58.00	AGGREGATE-MAGNETIC RESONANCE IMAGING	0	0	0	630,000		9.00
10.00	76.00	AGGREGATE-ONCOLOGY & PAIN MANAGEMENT	0	0	0	1,229,416		10.00
11.00	76.00	AGGREGATE-ONCOLOGY & PAIN MANAGEMENT	0	0	0	163,762		11.00
12.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	554,402		12.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8-2
Date/Time Prepared:
7/13/2020 7:28 am

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
200.00	1.00	2.00	15.00	16.00	17.00	18.00	6,085,470	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet B
Part I
Date/Time Prepared:
7/13/2020 7:28 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4.03	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	4,997,766	4,997,766			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	6,330,624		6,330,624		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,229,967	27,222	1,929	1,259,118	4.00
4.03 00401	ADMITTING	1,565,727	60,076	4,717	32,937	1,663,457 4.03
5.00 00500	ADMINISTRATIVE & GENERAL	26,523,511	281,580	3,692,148	90,579	0 5.00
7.00 00700	OPERATION OF PLANT	3,492,883	1,944,325	19,473	28,286	0 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	360,796	12,172	265	0	0 8.00
9.00 00900	HOUSEKEEPING	1,802,552	28,782	5,512	33,000	0 9.00
10.00 01000	DIETARY	3,311,448	119,455	15,193	0	0 10.00
11.00 01100	CAFETERIA	-494,847	51,655	0	0	0 11.00
13.00 01300	NURSING ADMINISTRATION	1,067,973	5,478	41,833	21,991	0 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	605,220	49,309	32,643	5,871	0 14.00
15.00 01500	PHARMACY	12,283,809	30,652	4,235	53,606	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	5	58,770	2,272	0	0 16.00
17.00 01700	SOCIAL SERVICE	1,815,889	5,798	1,208	30,759	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	13,629,603	607,212	155,735	275,329	159,028 30.00
31.00 03100	INTENSIVE CARE UNIT	2,842,530	60,729	23,137	58,168	32,206 31.00
40.00 04000	SUBPROVIDER - IPF	1,626,575	81,311	2,346	34,273	16,007 40.00
43.00 04300	NURSERY	1,023,526	0	0	21,543	12,076 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	7,207,951	229,117	397,878	78,715	135,290 50.00
51.00 05100	RECOVERY ROOM	732,136	37,413	21,433	14,176	25,810 51.00
53.00 05300	ANESTHESIOLOGY	254,294	2,700	14,084	1,977	34,439 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,280,288	120,827	627,428	59,540	136,153 54.00
56.00 05600	RADIOISOTOPE	468,734	11,077	74,144	5,879	7,387 56.00
57.00 05700	CT SCAN	556,932	6,296	162,872	7,813	132,950 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	652,386	53,193	677	13,117	35,623 58.00
59.00 05900	CARDIAC CATHETERIZATION	1,175,249	19,487	165,658	17,922	32,150 59.00
60.00 06000	LABORATORY	4,165,891	159,137	288,956	36,069	147,734 60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	1,115,771	4,028	4,126	8,484	17,078 63.00
65.00 06500	RESPIRATORY THERAPY	1,584,781	17,063	15,347	28,793	26,820 65.00
66.00 06600	PHYSICAL THERAPY	1,795,168	60,032	8,821	35,235	24,052 66.00
67.00 06700	OCCUPATIONAL THERAPY	394,681	16,167	2,083	8,968	4,878 67.00
68.00 06800	SPEECH PATHOLOGY	300,403	5,533	0	6,498	3,718 68.00
69.00 06900	ELECTROCARDIOLOGY	1,274,482	55,904	63,962	24,921	89,117 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,214,117	0	0	0	36,296 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	6,860,150	0	0	0	73,088 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	110,331 73.00
74.00 07400	RENAL DIALYSIS	424,060	3,098	0	0	4,084 74.00
76.00 03020	ONCOLOGY & PAIN MANAGEMENT	1,431,033	19,664	41,755	24,814	20,061 76.00
76.01 03340	GASTROINTESTINAL SERVICES	1,361,117	37,867	27,842	20,707	25,654 76.01
76.02 03550	OP PSYCH	411,601	42,957	1,812	8,010	6,755 76.02
76.98 07698	HYPERBARI C OXYGEN THERAPY	203,561	0	0	0	7,575 76.98
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	4,400,842	183,979	29,021	85,842	252,099 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	3,262,726	10,800	378,335	60,027	54,998 95.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	130,543,911	4,520,865	6,328,880	1,233,849	1,663,457 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-509,526	11,464	421	867	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
192.01 19201	TWIN RIVERS MRI	0	0	0	0	0 192.01
192.02 19202	PHYSICIAN PRACTICES	7,859,909	0	0	0	0 192.02
193.00 19300	NONPAID WORKERS	12,989	17,661	0	263	0 193.00
193.01 19301	PHYSICIAN/PUBLIC RELATIONS	795,121	11,519	537	5,037	0 193.01
193.02 19302	MEDICAL OFFICE BUILDING	758,226	0	0	6,368	0 193.02
193.03 19303	HOME CARE PHARMACY	1,512,435	5,323	786	8,459	0 193.03
193.04 19304	MANAGEMENT SERVICES	0	0	0	0	0 193.04
193.05 19305	EUNICE SMITH NURSING HOME	0	0	0	0	0 193.05
193.06 19306	VACANT SPACE	0	428,920	0	0	0 193.06
193.07 19307	POB 2	713,507	0	0	4,275	0 193.07
193.08 19308	NON REIMBURSABLE MEALS	0	0	0	0	0 193.08
193.09 19309	COFFEE BAR	48,008	2,014	0	0	0 193.09
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	0 201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet B
Part I
Date/Time Prepared:
7/13/2020 7:28 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4.03	
202.00 TOTAL (sum lines 118 through 201)	141,734,580	4,997,766	6,330,624	1,259,118	1,663,457	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4A.03	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
4.03	00401	ADMINISTRATIVE					4.03
5.00	00500	ADMINISTRATIVE & GENERAL	30,587,818	30,587,818			5.00
7.00	00700	OPERATION OF PLANT	5,484,967	1,496,815	6,981,782		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	373,233	101,853	31,657	506,743	8.00
9.00	00900	HOUSEKEEPING	1,869,846	510,270	74,854	0	2,454,970
10.00	01000	DIETARY	3,446,096	940,419	310,668	0	110,931
11.00	01100	CAFETERIA	-443,192	0	134,340	0	47,969
13.00	01300	NURSING ADMINISTRATION	1,137,275	310,356	14,246	0	5,087
14.00	01400	CENTRAL SERVICES & SUPPLY	693,043	189,127	128,239	9,612	45,790
15.00	01500	PHARMACY	12,372,302	3,376,327	79,717	141	28,465
16.00	01600	MEDICAL RECORDS & LIBRARY	61,047	16,659	152,845	0	54,577
17.00	01700	SOCIAL SERVICE	1,853,654	505,851	15,080	0	5,385
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	14,826,907	4,046,197	1,579,182	213,438	563,884
31.00	03100	INTENSIVE CARE UNIT	3,016,770	823,258	157,938	31,657	56,395
40.00	04000	SUBPROVIDER - IPF	1,760,512	480,433	211,467	5,138	75,509
43.00	04300	NURSERY	1,057,145	288,489	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,048,951	2,196,510	595,866	61,618	212,767
51.00	05100	RECOVERY ROOM	830,968	226,766	97,301	3,299	34,744
53.00	05300	ANESTHESIOLOGY	307,494	83,913	7,022	0	2,507
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,224,236	1,152,769	314,236	25,756	112,205
56.00	05600	RADIOISOTOPE	567,221	154,791	28,808	327	10,286
57.00	05700	CT SCAN	866,863	236,562	16,375	12,821	5,847
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	754,996	206,034	138,340	1,108	49,397
59.00	05900	CARDIAC CATHETERIZATION	1,410,466	384,908	50,680	7,147	18,096
60.00	06000	LABORATORY	4,797,787	1,309,287	413,869	0	147,781
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,149,487	313,688	10,476	0	3,741
65.00	06500	RESPIRATORY THERAPY	1,672,804	456,498	44,377	0	15,846
66.00	06600	PHYSICAL THERAPY	1,923,308	524,859	156,125	2,256	55,748
67.00	06700	OCCUPATIONAL THERAPY	426,777	116,465	42,046	0	15,013
68.00	06800	SPEECH PATHOLOGY	316,152	86,276	14,389	0	5,138
69.00	06900	ELECTROCARDIOLOGY	1,508,386	411,629	145,391	90	51,915
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,250,413	887,018	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,933,238	1,892,039	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	110,331	30,109	0	0	0
74.00	07400	RENAL DIALYSIS	431,242	117,683	8,058	0	2,877
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	1,537,327	419,527	51,140	0	18,261
76.01	03340	GASTRO INTESTINAL SERVICES	1,473,187	402,024	98,481	17,665	35,165
76.02	03550	OP PSYCH	471,135	128,570	111,720	3	39,892
76.98	07698	HYPERBARIC OXYGEN THERAPY	211,136	57,618	0	1,182	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	4,951,783	1,351,312	478,477	93,165	170,851
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0				
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	3,766,886	1,027,961	28,088	20,320	10,030
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	130,039,997	27,260,870	5,741,498	506,743	2,012,099
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-496,774	0	29,815	0	10,646
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0
192.02	19202	PHYSICIAN PRACTICES	7,859,909	2,144,922	0	0	0
193.00	19300	NONPAID WORKERS	30,913	8,436	45,931	0	16,401
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	812,214	221,648	29,959	0	10,697
193.02	19302	MEDICAL OFFICE BUILDING	764,594	208,653	0	0	0
193.03	19303	HOME CARE PHARMACY	1,527,003	416,710	13,843	0	4,943
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0
193.05	19305	EUNICE SMITH NURSING HOME	0	0	0	0	0
193.06	19306	VACANT SPACE	428,920	117,050	1,115,498	0	398,314
193.07	19307	POB 2	717,782	195,878	0	0	0
193.08	19308	NON REIMBURSABLE MEALS	0	0	0	0	0
193.09	19309	COFFEE BAR	50,022	13,651	5,238	0	1,870
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	141,734,580	30,587,818	6,981,782	506,743	2,454,970

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet B
Part I
Date/Time Prepared:
7/13/2020 7:28 am

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
4.03	00401						4.03
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	4,808,114					10.00
11.00	01100	2,422,941	2,162,058				11.00
13.00	01300	0	32,179	1,499,143			13.00
14.00	01400	0	20,084	0	1,085,895		14.00
15.00	01500	0	76,083	0	0	15,933,035	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	56,184	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	861,698	568,755	1,094,518	0	0	30.00
31.00	03100	89,451	96,574	175,419	0	0	31.00
40.00	04000	82,746	54,593	99,147	0	0	40.00
43.00	04300	0	36,987	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	151,685	0	0	0	50.00
51.00	05100	0	21,194	0	0	0	51.00
53.00	05300	0	5,104	0	0	0	53.00
54.00	05400	0	122,354	0	0	0	54.00
56.00	05600	0	7,989	0	0	0	56.00
57.00	05700	0	14,055	0	0	0	57.00
58.00	05800	0	25,965	0	0	0	58.00
59.00	05900	0	31,365	0	0	0	59.00
60.00	06000	0	107,300	0	0	0	60.00
63.00	06300	0	17,347	0	0	0	63.00
65.00	06500	0	52,670	0	0	0	65.00
66.00	06600	0	56,665	0	0	0	66.00
67.00	06700	0	15,720	0	0	0	67.00
68.00	06800	0	9,062	0	0	0	68.00
69.00	06900	0	49,378	0	0	0	69.00
71.00	07100	0	0	0	346,446	0	71.00
72.00	07200	0	0	0	739,449	0	72.00
73.00	07300	0	0	0	0	15,933,035	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03020	0	53,521	65,953	0	0	76.00
76.01	03340	0	36,285	64,106	0	0	76.01
76.02	03550	0	19,788	0	0	0	76.02
76.98	07698	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	0	169,402	0	0	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	187,267	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		3,456,836	2,095,555	1,499,143	1,085,895	15,933,035	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	3,625	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
193.00	19300	0	1,258	0	0	0	193.00
193.01	19301	0	7,397	0	0	0	193.01
193.02	19302	0	20,935	0	0	0	193.02
193.03	19303	0	16,977	0	0	0	193.03
193.04	19304	0	0	0	0	0	193.04
193.05	19305	1,042,898	0	0	0	0	193.05
193.06	19306	0	0	0	0	0	193.06
193.07	19307	0	16,311	0	0	0	193.07
193.08	19308	308,380	0	0	0	0	193.08
193.09	19309	0	0	0	0	0	193.09
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		4,808,114	2,162,058	1,499,143	1,085,895	15,933,035	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet B
Part I
Date/Time Prepared:
7/13/2020 7:28 am

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.03	00401	ADMITTING						4.03
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	285,128					16.00
17.00	01700	SOCIAL SERVICE	0	2,436,154				17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	27,271	1,908,283	25,690,133	0	25,690,133	30.00
31.00	03100	INTENSIVE CARE UNIT	5,523	198,082	4,651,067	0	4,651,067	31.00
40.00	04000	SUBPROVIDER - IPF	2,745	183,245	2,955,535	0	2,955,535	40.00
43.00	04300	NURSERY	2,071	146,544	1,531,236	0	1,531,236	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	23,200	0	11,290,597	0	11,290,597	50.00
51.00	05100	RECOVERY ROOM	4,426	0	1,218,698	0	1,218,698	51.00
53.00	05300	ANESTHESIOLOGY	5,906	0	411,946	0	411,946	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,348	0	5,974,904	0	5,974,904	54.00
56.00	05600	RADIOISOTOPE	1,267	0	770,689	0	770,689	56.00
57.00	05700	CT SCAN	22,799	0	1,175,322	0	1,175,322	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,109	0	1,181,949	0	1,181,949	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,513	0	1,908,175	0	1,908,175	59.00
60.00	06000	LABORATORY	25,334	0	6,801,358	0	6,801,358	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,929	0	1,497,668	0	1,497,668	63.00
65.00	06500	RESPIRATORY THERAPY	4,599	0	2,246,794	0	2,246,794	65.00
66.00	06600	PHYSICAL THERAPY	4,125	0	2,723,086	0	2,723,086	66.00
67.00	06700	OCCUPATIONAL THERAPY	836	0	616,857	0	616,857	67.00
68.00	06800	SPEECH PATHOLOGY	638	0	431,655	0	431,655	68.00
69.00	06900	ELECTROCARDIOLOGY	15,282	0	2,182,071	0	2,182,071	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,224	0	4,490,101	0	4,490,101	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	12,533	0	9,577,259	0	9,577,259	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,920	0	16,092,395	0	16,092,395	73.00
74.00	07400	RENAL DIALYSIS	700	0	560,560	0	560,560	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	3,440	0	2,149,169	0	2,149,169	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	4,399	0	2,131,312	0	2,131,312	76.01
76.02	03550	OP PSYCH	1,158	0	772,266	0	772,266	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,299	0	271,235	0	271,235	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	43,103	0	7,258,093	0	7,258,093	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	9,431	0	5,049,983	0	5,049,983	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	285,128	2,436,154	123,612,113	0	123,612,113	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	-452,688	0	-452,688	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0	192.01
192.02	19202	PHYSICIAN PRACTICES	0	0	10,004,831	0	10,004,831	192.02
193.00	19300	NONPAID WORKERS	0	0	102,939	0	102,939	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	0	0	1,081,915	0	1,081,915	193.01
193.02	19302	MEDICAL OFFICE BUILDING	0	0	994,182	0	994,182	193.02
193.03	19303	HOME CARE PHARMACY	0	0	1,979,476	0	1,979,476	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	1,042,898	0	1,042,898	193.05
193.06	19306	VACANT SPACE	0	0	2,059,782	0	2,059,782	193.06
193.07	19307	POB 2	0	0	929,971	0	929,971	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	308,380	0	308,380	193.08
193.09	19309	COFFEE BAR	0	0	70,781	0	70,781	193.09
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	285,128	2,436,154	141,734,580	0	141,734,580	202.00

COST ALLOCATION STATISTICS

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet Non-CMS W
Date/Time Prepared:
7/13/2020 7:28 am

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	NEW CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	5	GROSS SALARIES	4.00
4.03	ADMINISTRATIVE	7	GROSS REVENUE	4.03
5.00	ADMINISTRATIVE & GENERAL	-21	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	12	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	14	MEALS SERVED	10.00
11.00	CAFETERIA	15	FTE'S	11.00
13.00	NURSING ADMINISTRATION	16	HOURS OF SERVICE	13.00
14.00	CENTRAL SERVICES & SUPPLY	17	COSTED REQUISITIONS	14.00
15.00	PHARMACY	18	COSTED REQUISITIONS	15.00
16.00	MEDICAL RECORDS & LIBRARY	7	GROSS REVENUE	16.00
17.00	SOCIAL SERVICE	20	PATIENT DAYS	17.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet B
Part II
Date/Time Prepared:
7/13/2020 7:28 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	5,545	27,222	1,929	34,696	34,696 4.00
4.03 00401	ADMINISTRATIVE	4,749	60,076	4,717	69,542	907 4.03
5.00 00500	ADMINISTRATIVE & GENERAL	692,872	281,580	3,692,148	4,666,600	2,495 5.00
7.00 00700	OPERATION OF PLANT	4,205	1,944,325	19,473	1,968,003	779 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	12,172	265	12,437	0 8.00
9.00 00900	HOUSEKEEPING	481	28,782	5,512	34,775	909 9.00
10.00 01000	DIETARY	13,361	119,455	15,193	148,009	0 10.00
11.00 01100	CAFETERIA	0	51,655	0	51,655	0 11.00
13.00 01300	NURSING ADMINISTRATION	0	5,478	41,833	47,311	606 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	447	49,309	32,643	82,399	162 14.00
15.00 01500	PHARMACY	120,809	30,652	4,235	155,696	1,477 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	58,770	2,272	61,042	0 16.00
17.00 01700	SOCIAL SERVICE	2,792	5,798	1,208	9,798	847 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	277,237	607,212	155,735	1,040,184	7,597 30.00
31.00 03100	INTENSIVE CARE UNIT	2,100	60,729	23,137	85,966	1,602 31.00
40.00 04000	SUBPROVIDER - IPF	1,782	81,311	2,346	85,439	944 40.00
43.00 04300	NURSERY	0	0	0	0	593 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	32,180	229,117	397,878	659,175	2,168 50.00
51.00 05100	RECOVERY ROOM	409	37,413	21,433	59,255	390 51.00
53.00 05300	ANESTHESIOLOGY	0	2,700	14,084	16,784	54 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	120,827	627,428	748,255	1,640 54.00
56.00 05600	RADIOISOTOPE	5,374	11,077	74,144	90,595	162 56.00
57.00 05700	CT SCAN	0	6,296	162,872	169,168	215 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	2,168	53,193	677	56,038	361 58.00
59.00 05900	CARDIAC CATHETERIZATION	584	19,487	165,658	185,729	494 59.00
60.00 06000	LABORATORY	21,278	159,137	288,956	469,371	994 60.00
63.00 06300	BLOOD STORAGE, PROCESSING & TRANS.	0	4,028	4,126	8,154	234 63.00
65.00 06500	RESPIRATORY THERAPY	45,337	17,063	15,347	77,747	793 65.00
66.00 06600	PHYSICAL THERAPY	2,968	60,032	8,821	71,821	971 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	16,167	2,083	18,250	247 67.00
68.00 06800	SPEECH PATHOLOGY	0	5,533	0	5,533	179 68.00
69.00 06900	ELECTROCARDIOLOGY	5,762	55,904	63,962	125,628	686 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	0	3,098	0	3,098	0 74.00
76.00 03020	ONCOLOGY & PAIN MANAGEMENT	5,783	19,664	41,755	67,202	684 76.00
76.01 03340	GASTROINTESTINAL SERVICES	4,519	37,867	27,842	70,228	570 76.01
76.02 03550	OP PSYCH	3,458	42,957	1,812	48,227	221 76.02
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	3,838	183,979	29,021	216,838	2,365 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	-134	10,800	378,335	389,001	1,654 95.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,259,904	4,520,865	6,328,880	12,109,649	34,000 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,464	421	11,885	24 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
192.01 19201	TWIN RIVERS MRI	0	0	0	0	0 192.01
192.02 19202	PHYSICIAN PRACTICES	0	0	0	0	0 192.02
193.00 19300	NONPAID WORKERS	0	17,661	0	17,661	7 193.00
193.01 19301	PHYSICIAN/PUBLIC RELATIONS	589	11,519	537	12,645	139 193.01
193.02 19302	MEDICAL OFFICE BUILDING	0	0	0	0	0 193.02
193.03 19303	HOME CARE PHARMACY	557	5,323	786	6,666	233 193.03
193.04 19304	MANAGEMENT SERVICES	0	0	0	0	0 193.04
193.05 19305	EUNICE SMITH NURSING HOME	0	0	0	0	0 193.05
193.06 19306	VACANT SPACE	0	428,920	0	428,920	0 193.06
193.07 19307	POB 2	0	0	0	0	118 193.07
193.08 19308	NON REIMBURSABLE MEALS	0	0	0	0	0 193.08
193.09 19309	COFFEE BAR	0	2,014	0	2,014	0 193.09
200.00	Cross Foot Adjustments				0	0 200.00
201.00	Negative Cost Centers				0	0 201.00
202.00	TOTAL (sum lines 118 through 201)	1,261,050	4,997,766	6,330,624	12,589,440	34,696 202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet B Part II Date/Time Prepared: 7/13/2020 7:28 am		
Cost Center Description			ADMINISTRATIVE	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING
			4.03	5.00	7.00	8.00	9.00
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
4.03	00401	ADMINISTRATIVE	70,449				4.03
5.00	00500	ADMINISTRATIVE & GENERAL	0	4,669,095			5.00
7.00	00700	OPERATION OF PLANT	0	228,482	2,197,264		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,547	9,963	37,947	8.00
9.00	00900	HOUSEKEEPING	0	77,890	23,558	0	137,132
10.00	01000	DIETARY	0	143,551	97,772	0	6,196
11.00	01100	CAFETERIA	0	0	42,279	0	2,679
13.00	01300	NURSING ADMINISTRATION	0	47,374	4,483	0	284
14.00	01400	CENTRAL SERVICES & SUPPLY	0	28,869	40,358	720	2,558
15.00	01500	PHARMACY	0	515,381	25,088	11	1,590
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,543	48,102	0	3,049
17.00	01700	SOCIAL SERVICE	0	77,216	4,746	0	301
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,739	617,640	496,991	15,980	31,497
31.00	03100	INTENSIVE CARE UNIT	1,365	125,667	49,705	2,371	3,150
40.00	04000	SUBPROVIDER - IPF	678	73,336	66,552	385	4,218
43.00	04300	NURSERY	512	44,036	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,733	335,287	187,527	4,614	11,885
51.00	05100	RECOVERY ROOM	1,094	34,615	30,622	247	1,941
53.00	05300	ANESTHESIOLOGY	1,459	12,809	2,210	0	140
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,770	175,965	98,895	1,929	6,268
56.00	05600	RADIOLOGY-SOFT	313	23,628	9,066	25	575
57.00	05700	CT SCAN	5,634	36,110	5,153	960	327
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,510	31,450	43,538	83	2,759
59.00	05900	CARDIAC CATHETERIZATION	1,362	58,754	15,950	535	1,011
60.00	06000	LABORATORY	6,261	199,857	130,250	0	8,255
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	724	47,883	3,297	0	209
65.00	06500	RESPIRATORY THERAPY	1,137	69,682	13,966	0	885
66.00	06600	PHYSICAL THERAPY	1,019	80,117	49,135	169	3,114
67.00	06700	OCCUPATIONAL THERAPY	207	17,778	13,232	0	839
68.00	06800	SPEECH PATHOLOGY	158	13,170	4,529	0	287
69.00	06900	ELECTROCARDIOLOGY	3,777	62,833	45,757	7	2,900
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,538	135,399	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,097	288,811	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	4,676	4,596	0	0	0
74.00	07400	RENAL DIALYSIS	173	17,964	2,536	0	161
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	850	64,039	16,094	0	1,020
76.01	03340	GASTRO INTESTINAL SERVICES	1,087	61,367	30,993	1,323	1,964
76.02	03550	OP PSYCH	286	19,626	35,160	0	2,228
76.98	07698	HYPERBARIC OXYGEN THERAPY	321	8,795	0	89	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	10,638	206,271	150,584	6,977	9,544
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	2,331	156,913	8,840	1,522	560
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	70,449	4,161,251	1,806,931	37,947	112,394
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	9,383	0	595
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0
192.02	19202	PHYSICIAN PRACTICES	0	327,412	0	0	0
193.00	19300	NONPAID WORKERS	0	1,288	14,455	0	916
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	0	33,834	9,428	0	598
193.02	19302	MEDICAL OFFICE BUILDING	0	31,850	0	0	0
193.03	19303	HOME CARE PHARMACY	0	63,609	4,356	0	276
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0
193.05	19305	EUNICE SMITH NURSING HOME	0	0	0	0	0
193.06	19306	VACANT SPACE	0	17,867	351,063	0	22,249
193.07	19307	POB 2	0	29,900	0	0	0
193.08	19308	NON REIMBURSABLE MEALS	0	0	0	0	0
193.09	19309	COFFEE BAR	0	2,084	1,648	0	104
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	70,449	4,669,095	2,197,264	37,947	137,132

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet B
Part II
Date/Time Prepared:
7/13/2020 7:28 am

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
4.03	00401						4.03
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	395,528					10.00
11.00	01100	199,318	240,814				11.00
13.00	01300	0	3,584	103,642			13.00
14.00	01400	0	2,237	0	157,303		14.00
15.00	01500	0	8,474	0	0	707,717	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	6,258	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	70,885	63,349	75,669	0	0	30.00
31.00	03100	7,358	10,757	12,127	0	0	31.00
40.00	04000	6,807	6,081	6,854	0	0	40.00
43.00	04300	0	4,120	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	16,895	0	0	0	50.00
51.00	05100	0	2,361	0	0	0	51.00
53.00	05300	0	569	0	0	0	53.00
54.00	05400	0	13,628	0	0	0	54.00
56.00	05600	0	890	0	0	0	56.00
57.00	05700	0	1,565	0	0	0	57.00
58.00	05800	0	2,892	0	0	0	58.00
59.00	05900	0	3,494	0	0	0	59.00
60.00	06000	0	11,951	0	0	0	60.00
63.00	06300	0	1,932	0	0	0	63.00
65.00	06500	0	5,866	0	0	0	65.00
66.00	06600	0	6,311	0	0	0	66.00
67.00	06700	0	1,751	0	0	0	67.00
68.00	06800	0	1,009	0	0	0	68.00
69.00	06900	0	5,500	0	0	0	69.00
71.00	07100	0	0	0	50,185	0	71.00
72.00	07200	0	0	0	107,118	0	72.00
73.00	07300	0	0	0	0	707,717	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03020	0	5,961	4,560	0	0	76.00
76.01	03340	0	4,041	4,432	0	0	76.01
76.02	03550	0	2,204	0	0	0	76.02
76.98	07698	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	0	18,868	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	20,858	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		284,368	233,406	103,642	157,303	707,717	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	404	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
193.00	19300	0	140	0	0	0	193.00
193.01	19301	0	824	0	0	0	193.01
193.02	19302	0	2,332	0	0	0	193.02
193.03	19303	0	1,891	0	0	0	193.03
193.04	19304	0	0	0	0	0	193.04
193.05	19305	85,792	0	0	0	0	193.05
193.06	19306	0	0	0	0	0	193.06
193.07	19307	0	1,817	0	0	0	193.07
193.08	19308	25,368	0	0	0	0	193.08
193.09	19309	0	0	0	0	0	193.09
200.00							200.00
201.00		0	55,117	0	0	0	201.00
202.00		395,528	295,931	103,642	157,303	707,717	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet B Part II Date/Time Prepared: 7/13/2020 7:28 am
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Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
4.03	00401	ADMITTING					4.03
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	114,736				16.00
17.00	01700	SOCIAL SERVICE	0	99,166			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	10,971	77,679	2,515,181	0	2,515,181
31.00	03100	INTENSIVE CARE UNIT	2,222	8,063	310,353	0	310,353
40.00	04000	SUBPROVIDER - IPF	1,104	7,459	259,857	0	259,857
43.00	04300	NURSERY	833	5,965	56,059	0	56,059
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,333	0	1,232,617	0	1,232,617
51.00	05100	RECOVERY ROOM	1,781	0	132,306	0	132,306
53.00	05300	ANESTHESIOLOGY	2,376	0	36,401	0	36,401
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,393	0	1,061,743	0	1,061,743
56.00	05600	RADIOISOTOPE	510	0	125,764	0	125,764
57.00	05700	CT SCAN	9,172	0	228,304	0	228,304
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,458	0	141,089	0	141,089
59.00	05900	CARDIAC CATHETERIZATION	2,218	0	269,547	0	269,547
60.00	06000	LABORATORY	10,192	0	837,131	0	837,131
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,178	0	63,611	0	63,611
65.00	06500	RESPIRATORY THERAPY	1,850	0	171,926	0	171,926
66.00	06600	PHYSICAL THERAPY	1,659	0	214,316	0	214,316
67.00	06700	OCCUPATIONAL THERAPY	336	0	52,640	0	52,640
68.00	06800	SPEECH PATHOLOGY	256	0	25,121	0	25,121
69.00	06900	ELECTROCARDIOLOGY	6,148	0	253,236	0	253,236
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,504	0	189,626	0	189,626
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,042	0	404,068	0	404,068
73.00	07300	DRUGS CHARGED TO PATIENTS	7,612	0	724,601	0	724,601
74.00	07400	RENAL DIALYSIS	282	0	24,214	0	24,214
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	1,384	0	161,794	0	161,794
76.01	03340	GASTRO INTESTINAL SERVICES	1,770	0	177,775	0	177,775
76.02	03550	OP PSYCH	466	0	108,418	0	108,418
76.98	07698	HYPERBARIC OXYGEN THERAPY	523	0	9,728	0	9,728
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	17,369	0	639,454	0	639,454
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	3,794	0	585,473	0	585,473
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	114,736	99,166	11,012,353	0	11,012,353
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	22,291	0	22,291
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0
192.02	19202	PHYSICIAN PRACTICES	0	0	327,412	0	327,412
193.00	19300	NONPAID WORKERS	0	0	34,467	0	34,467
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	0	0	57,468	0	57,468
193.02	19302	MEDICAL OFFICE BUILDING	0	0	34,357	0	34,357
193.03	19303	HOME CARE PHARMACY	0	0	77,031	0	77,031
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0
193.05	19305	EUNICE SMITH NURSING HOME	0	0	85,792	0	85,792
193.06	19306	VACANT SPACE	0	0	820,099	0	820,099
193.07	19307	POB 2	0	0	31,835	0	31,835
193.08	19308	NON REIMBURSABLE MEALS	0	0	25,368	0	25,368
193.09	19309	COFFEE BAR	0	0	5,850	0	5,850
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	55,117	0	55,117
202.00		TOTAL (sum lines 118 through 201)	114,736	99,166	12,589,440	0	12,589,440

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1
Date/Time Prepared:
7/13/2020 7:28 am

Cost Center Description	CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS REVENUE)	Reconciliation	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)						
	1.00	2.00	4.00	4.03				
GENERAL SERVICE COST CENTERS								
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	451,642						1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		6,263,055					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,460	1,908	45,279,678				4.00
4.03 00401	ADMITTING	5,429	4,667	1,184,428	546,522,352			4.03
5.00 00500	ADMINISTRATIVE & GENERAL	25,446	3,652,739	3,257,284	0	-30,587,818		5.00
7.00 00700	OPERATION OF PLANT	175,706	19,265	1,017,207	0	0		7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,100	262	0	0	0		8.00
9.00 00900	HOUSEKEEPING	2,601	5,453	1,186,693	0	0		9.00
10.00 01000	DIETARY	10,795	15,031	0	0	0		10.00
11.00 01100	CAFETERIA	4,668	0	0	0	443,192		11.00
13.00 01300	NURSING ADMINISTRATION	495	41,386	790,804	0	0		13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	4,456	32,295	211,128	0	0		14.00
15.00 01500	PHARMACY	2,770	4,190	1,927,730	0	0		15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	5,311	2,248	0	0	0		16.00
17.00 01700	SOCIAL SERVICE	524	1,195	1,106,122	0	0		17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00 03000	ADULTS & PEDIATRICS	54,873	154,073	9,901,670	52,243,069	0		30.00
31.00 03100	INTENSIVE CARE UNIT	5,488	22,890	2,091,760	10,580,045	0		31.00
40.00 04000	SUBPROVIDER - IPF	7,348	2,321	1,232,493	5,258,587	0		40.00
43.00 04300	NURSERY	0	0	774,716	3,967,081	0		43.00
ANCILLARY SERVICE COST CENTERS								
50.00 05000	OPERATING ROOM	20,705	393,631	2,830,651	44,444,837	0		50.00
51.00 05100	RECOVERY ROOM	3,381	21,204	509,782	8,478,833	0		51.00
53.00 05300	ANESTHESIOLOGY	244	13,934	71,086	11,313,779	0		53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	10,919	620,731	2,141,120	44,728,239	0		54.00
56.00 05600	RADIOISOTOPE	1,001	73,353	211,430	2,426,791	0		56.00
57.00 05700	CT SCAN	569	161,134	280,972	43,676,154	0		57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	4,807	670	471,708	11,702,672	0		58.00
59.00 05900	CARDIAC CATHETERIZATION	1,761	163,890	644,490	10,561,834	0		59.00
60.00 06000	LABORATORY	14,381	285,872	1,297,090	48,532,839	0		60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	364	4,082	305,102	5,610,388	0		63.00
65.00 06500	RESPIRATORY THERAPY	1,542	15,183	1,035,434	8,810,638	0		65.00
66.00 06600	PHYSICAL THERAPY	5,425	8,727	1,267,092	7,901,512	0		66.00
67.00 06700	OCCUPATIONAL THERAPY	1,461	2,061	322,508	1,602,339	0		67.00
68.00 06800	SPEECH PATHOLOGY	500	0	233,690	1,221,276	0		68.00
69.00 06900	ELECTROCARDIOLOGY	5,052	63,279	896,188	29,276,429	0		69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	11,923,764	0		71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	24,010,525	0		72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	36,245,520	0		73.00
74.00 07400	RENAL DIALYSIS	280	0	0	1,341,648	0		74.00
76.00 03020	ONCOLOGY & PAIN MANAGEMENT	1,777	41,309	892,340	6,590,477	0		76.00
76.01 03340	GASTROINTESTINAL SERVICES	3,422	27,545	744,642	8,427,711	0		76.01
76.02 03550	OP PSYCH	3,882	1,793	288,056	2,219,191	0		76.02
76.98 07698	HYPERBARI C OXYGEN THERAPY	0	0	0	2,488,380	0		76.98
OUTPATIENT SERVICE COST CENTERS								
91.00 09100	EMERGENCY	16,626	28,711	3,086,958	82,870,094	0		91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)							92.00
OTHER REIMBURSABLE COST CENTERS								
95.00 09500	AMBULANCE SERVICES	976	374,297	2,158,627	18,067,700	0		95.00
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	408,545	6,261,329	44,371,001	546,522,352	-30,144,626		118.00
NONREIMBURSABLE COST CENTERS								
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,036	417	31,181	0	496,774		190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0		192.00
192.01 19201	TWIN RIVERS MRI	0	0	0	0	0		192.01
192.02 19202	PHYSICIAN PRACTICES	0	0	0	0	0		192.02
193.00 19300	NONPAID WORKERS	1,596	0	9,460	0	0		193.00
193.01 19301	PHYSICIAN/PUBLIC RELATIONS	1,041	531	181,117	0	0		193.01
193.02 19302	MEDICAL OFFICE BUILDING	0	0	228,983	0	0		193.02
193.03 19303	HOME CARE PHARMACY	481	778	304,202	0	0		193.03
193.04 19304	MANAGEMENT SERVICES	0	0	0	0	0		193.04
193.05 19305	EUNICE SMITH NURSING HOME	0	0	0	0	0		193.05
193.06 19306	VACANT SPACE	38,761	0	0	0	0		193.06
193.07 19307	POB 2	0	0	153,734	0	0		193.07
193.08 19308	NON REIMBURSABLE MEALS	0	0	0	0	0		193.08
193.09 19309	COFFEE BAR	182	0	0	0	0		193.09
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers							201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
7/13/2020 7:28 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS REVENUE)	Reconciliation	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
202.00	Cost to be allocated (per Wkst. B, Part I)	4,997,766	6,330,624	1,259,118	1,663,457	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	11.065769	1.010789	0.027808	0.003044	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			34,696	70,449	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000766	0.000129	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1
Date/Time Prepared:
7/13/2020 7:28 am

Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)		
		5.00	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
4.03	00401	ADMITTING					4.03	
5.00	00500	ADMINISTRATIVE & GENERAL	112,086,728				5.00	
7.00	00700	OPERATION OF PLANT	5,484,967	242,601			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	373,233	1,100	526,396		8.00	
9.00	00900	HOUSEKEEPING	1,869,846	2,601	0	238,900	9.00	
10.00	01000	DIETARY	3,446,096	10,795	0	10,795	378,624	10.00
11.00	01100	CAFETERIA	0	4,668	0	4,668	190,799	11.00
13.00	01300	NURSING ADMINISTRATION	1,137,275	495	0	495	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	693,043	4,456	9,985	4,456	0	14.00
15.00	01500	PHARMACY	12,372,302	2,770	146	2,770	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	61,047	5,311	0	5,311	0	16.00
17.00	01700	SOCIAL SERVICE	1,853,654	524	0	524	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,826,907	54,873	221,717	54,873	67,856	30.00
31.00	03100	INTENSIVE CARE UNIT	3,016,770	5,488	32,885	5,488	7,044	31.00
40.00	04000	SUBPROVIDER - IPF	1,760,512	7,348	5,337	7,348	6,516	40.00
43.00	04300	NURSERY	1,057,145	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,048,951	20,705	64,008	20,705	0	50.00
51.00	05100	RECOVERY ROOM	830,968	3,381	3,427	3,381	0	51.00
53.00	05300	ANESTHESIOLOGY	307,494	244	0	244	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,224,236	10,919	26,755	10,919	0	54.00
56.00	05600	RADIOISOTOPE	567,221	1,001	340	1,001	0	56.00
57.00	05700	CT SCAN	866,863	569	13,318	569	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	754,996	4,807	1,151	4,807	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,410,466	1,761	7,424	1,761	0	59.00
60.00	06000	LABORATORY	4,797,787	14,381	0	14,381	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,149,487	364	0	364	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,672,804	1,542	0	1,542	0	65.00
66.00	06600	PHYSICAL THERAPY	1,923,308	5,425	2,343	5,425	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	426,777	1,461	0	1,461	0	67.00
68.00	06800	SPEECH PATHOLOGY	316,152	500	0	500	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,508,386	5,052	93	5,052	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,250,413	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,933,238	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	110,331	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	431,242	280	0	280	0	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	1,537,327	1,777	0	1,777	0	76.00
76.01	03340	GASTROINTESTINAL SERVICES	1,473,187	3,422	18,350	3,422	0	76.01
76.02	03550	OP PSYCH	471,135	3,882	3	3,882	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	211,136	0	1,228	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	4,951,783	16,626	96,778	16,626	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	3,766,886	976	21,108	976	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	99,895,371	199,504	526,396	195,803	272,215	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,036	0	1,036	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0	192.01
192.02	19202	PHYSICIAN PRACTICES	7,859,909	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	30,913	1,596	0	1,596	0	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	812,214	1,041	0	1,041	0	193.01
193.02	19302	MEDICAL OFFICE BUILDING	764,594	0	0	0	0	193.02
193.03	19303	HOME CARE PHARMACY	1,527,003	481	0	481	0	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	0	0	82,125	193.05
193.06	19306	VACANT SPACE	428,920	38,761	0	38,761	0	193.06
193.07	19307	POB 2	717,782	0	0	0	0	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	0	0	24,284	193.08
193.09	19309	COFFEE BAR	50,022	182	0	182	0	193.09
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)	30,587,818	6,981,782	506,743	2,454,970	4,808,114	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.272894	28.778867	0.962665	10.276141	12.698915	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
7/13/2020 7:28 am

Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	4,669,095	2,197,264	37,947	137,132	395,528	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.041656	9.057110	0.072088	0.574014	1.044646	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1
Date/Time Prepared:
7/13/2020 7:28 am

Cost Center Description			CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIREMENTS)	PHARMACY (COSTED REQUIREMENTS)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.03	00401	ADMINISTRATIVE						4.03
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	58,454					11.00
13.00	01300	NURSING ADMINISTRATION	870	464,153				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	543	0	10,074,267			14.00
15.00	01500	PHARMACY	2,057	0	0	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	546,522,352	16.00
17.00	01700	SOCIAL SERVICE	1,519	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,377	338,876	0	0	52,243,069	30.00
31.00	03100	INTENSIVE CARE UNIT	2,611	54,312	0	0	10,580,045	31.00
40.00	04000	SUBPROVIDER - IPF	1,476	30,697	0	0	5,258,587	40.00
43.00	04300	NURSERY	1,000	0	0	0	3,967,081	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,101	0	0	0	44,444,837	50.00
51.00	05100	RECOVERY ROOM	573	0	0	0	8,478,833	51.00
53.00	05300	ANESTHESIOLOGY	138	0	0	0	11,313,779	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,308	0	0	0	44,728,239	54.00
56.00	05600	RADIOISOTOPE	216	0	0	0	2,426,791	56.00
57.00	05700	CT SCAN	380	0	0	0	43,676,154	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	702	0	0	0	11,702,672	58.00
59.00	05900	CARDIAC CATHETERIZATION	848	0	0	0	10,561,834	59.00
60.00	06000	LABORATORY	2,901	0	0	0	48,532,839	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	469	0	0	0	5,610,388	63.00
65.00	06500	RESPIRATORY THERAPY	1,424	0	0	0	8,810,638	65.00
66.00	06600	PHYSICAL THERAPY	1,532	0	0	0	7,901,512	66.00
67.00	06700	OCCUPATIONAL THERAPY	425	0	0	0	1,602,339	67.00
68.00	06800	SPEECH PATHOLOGY	245	0	0	0	1,221,276	68.00
69.00	06900	ELECTROCARDIOLOGY	1,335	0	0	0	29,276,429	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	3,214,117	0	11,923,764	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	6,860,150	0	24,010,525	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100	36,245,520	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	1,341,648	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	1,447	20,420	0	0	6,590,477	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	981	19,848	0	0	8,427,711	76.01
76.02	03550	OP PSYCH	535	0	0	0	2,219,191	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	2,488,380	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	4,580	0	0	0	82,870,094	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	5,063	0	0	0	18,067,700	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	56,656	464,153	10,074,267	100	546,522,352	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	98	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	TWIN RIVERS MRI	0	0	0	0	0	192.01
192.02	19202	PHYSICIAN PRACTICES	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	34	0	0	0	0	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	200	0	0	0	0	193.01
193.02	19302	MEDICAL OFFICE BUILDING	566	0	0	0	0	193.02
193.03	19303	HOME CARE PHARMACY	459	0	0	0	0	193.03
193.04	19304	MANAGEMENT SERVICES	0	0	0	0	0	193.04
193.05	19305	EUNICE SMITH NURSING HOME	0	0	0	0	0	193.05
193.06	19306	VACANT SPACE	0	0	0	0	0	193.06
193.07	19307	POB 2	441	0	0	0	0	193.07
193.08	19308	NON REIMBURSABLE MEALS	0	0	0	0	0	193.08
193.09	19309	COFFEE BAR	0	0	0	0	0	193.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,162,058	1,499,143	1,085,895	15,933,035	285,128	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
7/13/2020 7:28 am

Cost Center Description		CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIREMENTS)	PHARMACY (COSTED REQUIREMENTS)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
		11.00	13.00	14.00	15.00	16.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	36.987340	3.229847	0.107789	159,330.350000	0.000522	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	295,931	103,642	157,303	707,717	114,736	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	4.119718	0.223293	0.015614	7,077.170000	0.000210	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1
Date/Time Prepared:
7/13/2020 7:28 am

Cost Center Description		SOCIAL SERVICE (PATIENT DAYS) 17.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
4.03	00401	ADMITTING	4.03
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	76.00
76.01	03340	GASTROINTESTINAL SERVICES	76.01
76.02	03550	OP PSYCH	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	TWIN RIVERS MRI	192.01
192.02	19202	PHYSICIAN PRACTICES	192.02
193.00	19300	NONPAID WORKERS	193.00
193.01	19301	PHYSICIAN/PUBLIC RELATIONS	193.01
193.02	19302	MEDICAL OFFICE BUILDING	193.02
193.03	19303	HOME CARE PHARMACY	193.03
193.04	19304	MANAGEMENT SERVICES	193.04
193.05	19305	EUNICE SMITH NURSING HOME	193.05
193.06	19306	VACANT SPACE	193.06
193.07	19307	POB 2	193.07
193.08	19308	NON REIMBURSABLE MEALS	193.08
193.09	19309	COFFEE BAR	193.09
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)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet B-1 Date/Time Prepared: 7/13/2020 7:28 am
Cost Center Description		SOCIAL SERVICE (PATIENT DAYS)		
		17.00		
204.00	Cost to be allocated (per Wkst. B, Part II)	99,166		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	3.531804		205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)			206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)			207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepared: 7/13/2020 7:28 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		25,690,133	0	25,690,133	30.00
31.00	03100 INTENSIVE CARE UNIT		4,651,067	0	4,651,067	31.00
40.00	04000 SUBPROVIDER - I/PF		2,955,535	0	2,955,535	40.00
43.00	04300 NURSERY		1,531,236	0	1,531,236	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		11,290,597	0	11,290,597	50.00
51.00	05100 RECOVERY ROOM		1,218,698	0	1,218,698	51.00
53.00	05300 ANESTHESIOLOGY		411,946	0	411,946	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		5,974,904	0	5,974,904	54.00
56.00	05600 RADIOISOTOPE		770,689	0	770,689	56.00
57.00	05700 CT SCAN		1,175,322	0	1,175,322	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		1,181,949	0	1,181,949	58.00
59.00	05900 CARDIAC CATHETERIZATION		1,908,175	0	1,908,175	59.00
60.00	06000 LABORATORY		6,801,358	0	6,801,358	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		1,497,668	0	1,497,668	63.00
65.00	06500 RESPIRATORY THERAPY	0	2,246,794	0	2,246,794	65.00
66.00	06600 PHYSICAL THERAPY	0	2,723,086	0	2,723,086	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	616,857	0	616,857	67.00
68.00	06800 SPEECH PATHOLOGY	0	431,655	0	431,655	68.00
69.00	06900 ELECTROCARDIOLOGY		2,182,071	0	2,182,071	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		4,490,101	0	4,490,101	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		9,577,259	0	9,577,259	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		16,092,395	0	16,092,395	73.00
74.00	07400 RENAL DIALYSIS		560,560	0	560,560	74.00
76.00	03020 ONCOLOGY & PAIN MANAGEMENT		2,149,169	0	2,149,169	76.00
76.01	03340 GASTROINTESTINAL SERVICES		2,131,312	0	2,131,312	76.01
76.02	03550 OP PSYCH		772,266	0	772,266	76.02
76.98	07698 HYPERBARIC OXYGEN THERAPY		271,235	0	271,235	76.98
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY		7,258,093	0	7,258,093	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1,196,082	0	1,196,082	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES		5,049,983	0	5,049,983	95.00
200.00	Subtotal (see instructions)	0	124,808,195	0	124,808,195	200.00
201.00	Less Observation Beds		1,196,082		1,196,082	201.00
202.00	Total (see instructions)	0	123,612,113	0	123,612,113	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepared: 7/13/2020 7:28 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	50,310,675		50,310,675	30.00
31.00	03100	INTENSIVE CARE UNIT	10,580,045		10,580,045	31.00
40.00	04000	SUBPROVIDER - IPF	5,258,587		5,258,587	40.00
43.00	04300	NURSERY	3,967,081		3,967,081	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,306,692	33,138,145	44,444,837	50.00
51.00	05100	RECOVERY ROOM	1,713,834	6,764,999	8,478,833	51.00
53.00	05300	ANESTHESIOLOGY	3,575,673	7,738,106	11,313,779	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,785,697	38,942,542	44,728,239	54.00
56.00	05600	RADIOISOTOPE	663,188	1,763,603	2,426,791	56.00
57.00	05700	CT SCAN	11,126,689	32,549,465	43,676,154	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,382,815	10,319,857	11,702,672	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,390,458	6,171,376	10,561,834	59.00
60.00	06000	LABORATORY	20,559,332	27,973,507	48,532,839	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,778,953	2,831,435	5,610,388	63.00
65.00	06500	RESPIRATORY THERAPY	7,177,822	1,632,816	8,810,638	65.00
66.00	06600	PHYSICAL THERAPY	1,611,122	6,290,390	7,901,512	66.00
67.00	06700	OCCUPATIONAL THERAPY	733,271	869,068	1,602,339	67.00
68.00	06800	SPEECH PATHOLOGY	188,020	1,033,256	1,221,276	68.00
69.00	06900	ELECTROCARDIOLOGY	10,501,311	18,775,118	29,276,429	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,541,571	7,382,193	11,923,764	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	10,626,051	13,384,474	24,010,525	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,336,916	28,908,604	36,245,520	73.00
74.00	07400	RENAL DIALYSIS	1,315,444	26,204	1,341,648	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	13,775	6,576,702	6,590,477	76.00
76.01	03340	GASTROINTESTINAL SERVICES	1,380,969	7,046,742	8,427,711	76.01
76.02	03550	OP PSYCH	2,464	2,216,727	2,219,191	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	12,864	2,475,516	2,488,380	76.98
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	15,757,585	67,112,509	82,870,094	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	17,325	1,915,069	1,932,394	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	6,842	18,060,858	18,067,700	95.00
200.00		Subtotal (see instructions)	194,623,071	351,899,281	546,522,352	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	194,623,071	351,899,281	546,522,352	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepared: 7/13/2020 7:28 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
43.00	04300 NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.254036		50.00
51.00	05100 RECOVERY ROOM	0.143734		51.00
53.00	05300 ANESTHESIOLOGY	0.036411		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.133582		54.00
56.00	05600 RADIOISOTOPE	0.317575		56.00
57.00	05700 CT SCAN	0.026910		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.100998		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.180667		59.00
60.00	06000 LABORATORY	0.140139		60.00
63.00	06300 BLOOD STORAGE, PROCESSING & TRANS.	0.266946		63.00
65.00	06500 RESPIRATORY THERAPY	0.255009		65.00
66.00	06600 PHYSICAL THERAPY	0.344628		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.384973		67.00
68.00	06800 SPEECH PATHOLOGY	0.353446		68.00
69.00	06900 ELECTROCARDIOLOGY	0.074533		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.376567		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.398878		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.443983		73.00
74.00	07400 RENAL DIALYSIS	0.417815		74.00
76.00	03020 ONCOLOGY & PAIN MANAGEMENT	0.326102		76.00
76.01	03340 GASTROINTESTINAL SERVICES	0.252893		76.01
76.02	03550 OP PSYCH	0.347994		76.02
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.109001		76.98
	OUTPATIENT SERVICE COST CENTERS			
91.00	09100 EMERGENCY	0.087584		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.618964		92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	0.279503		95.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepared: 7/13/2020 7:28 am
		Title XIX	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		25,690,133	0	25,690,133	30.00
31.00	03100 INTENSIVE CARE UNIT		4,651,067	0	4,651,067	31.00
40.00	04000 SUBPROVIDER - I/PF		2,955,535	0	2,955,535	40.00
43.00	04300 NURSERY		1,531,236	0	1,531,236	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		11,290,597	0	11,290,597	50.00
51.00	05100 RECOVERY ROOM		1,218,698	0	1,218,698	51.00
53.00	05300 ANESTHESIOLOGY		411,946	0	411,946	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		5,974,904	0	5,974,904	54.00
56.00	05600 RADIOISOTOPE		770,689	0	770,689	56.00
57.00	05700 CT SCAN		1,175,322	0	1,175,322	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		1,181,949	0	1,181,949	58.00
59.00	05900 CARDIAC CATHETERIZATION		1,908,175	0	1,908,175	59.00
60.00	06000 LABORATORY		6,801,358	0	6,801,358	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		1,497,668	0	1,497,668	63.00
65.00	06500 RESPIRATORY THERAPY	0	2,246,794	0	2,246,794	65.00
66.00	06600 PHYSICAL THERAPY	0	2,723,086	0	2,723,086	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	616,857	0	616,857	67.00
68.00	06800 SPEECH PATHOLOGY	0	431,655	0	431,655	68.00
69.00	06900 ELECTROCARDIOLOGY		2,182,071	0	2,182,071	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		4,490,101	0	4,490,101	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		9,577,259	0	9,577,259	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		16,092,395	0	16,092,395	73.00
74.00	07400 RENAL DIALYSIS		560,560	0	560,560	74.00
76.00	03020 ONCOLOGY & PAIN MANAGEMENT		2,149,169	0	2,149,169	76.00
76.01	03340 GASTROINTESTINAL SERVICES		2,131,312	0	2,131,312	76.01
76.02	03550 OP PSYCH		772,266	0	772,266	76.02
76.98	07698 HYPERBARIC OXYGEN THERAPY		271,235	0	271,235	76.98
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY		7,258,093	0	7,258,093	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1,196,082	0	1,196,082	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES		5,049,983	0	5,049,983	95.00
200.00	Subtotal (see instructions)	0	124,808,195	0	124,808,195	200.00
201.00	Less Observation Beds		1,196,082		1,196,082	201.00
202.00	Total (see instructions)	0	123,612,113	0	123,612,113	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet C
Part I
Date/Time Prepared:
7/13/2020 7:28 am

		Title XIX			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	50,310,675		50,310,675		30.00
31.00	03100	INTENSIVE CARE UNIT	10,580,045		10,580,045		31.00
40.00	04000	SUBPROVIDER - IPF	5,258,587		5,258,587		40.00
43.00	04300	NURSERY	3,967,081		3,967,081		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	11,306,692	33,138,145	44,444,837	0.254036	50.00
51.00	05100	RECOVERY ROOM	1,713,834	6,764,999	8,478,833	0.143734	51.00
53.00	05300	ANESTHESIOLOGY	3,575,673	7,738,106	11,313,779	0.036411	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,785,697	38,942,542	44,728,239	0.133582	54.00
56.00	05600	RADIOISOTOPE	663,188	1,763,603	2,426,791	0.317575	56.00
57.00	05700	CT SCAN	11,126,689	32,549,465	43,676,154	0.026910	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,382,815	10,319,857	11,702,672	0.100998	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,390,458	6,171,376	10,561,834	0.180667	59.00
60.00	06000	LABORATORY	20,559,332	27,973,507	48,532,839	0.140139	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,778,953	2,831,435	5,610,388	0.266946	63.00
65.00	06500	RESPIRATORY THERAPY	7,177,822	1,632,816	8,810,638	0.255009	65.00
66.00	06600	PHYSICAL THERAPY	1,611,122	6,290,390	7,901,512	0.344628	66.00
67.00	06700	OCCUPATIONAL THERAPY	733,271	869,068	1,602,339	0.384973	67.00
68.00	06800	SPEECH PATHOLOGY	188,020	1,033,256	1,221,276	0.353446	68.00
69.00	06900	ELECTROCARDIOLOGY	10,501,311	18,775,118	29,276,429	0.074533	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,541,571	7,382,193	11,923,764	0.376567	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	10,626,051	13,384,474	24,010,525	0.398878	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,336,916	28,908,604	36,245,520	0.443983	73.00
74.00	07400	RENAL DIALYSIS	1,315,444	26,204	1,341,648	0.417815	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	13,775	6,576,702	6,590,477	0.326102	76.00
76.01	03340	GASTROINTESTINAL SERVICES	1,380,969	7,046,742	8,427,711	0.252893	76.01
76.02	03550	OP PSYCH	2,464	2,216,727	2,219,191	0.347994	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	12,864	2,475,516	2,488,380	0.109001	76.98
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	15,757,585	67,112,509	82,870,094	0.087584	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	17,325	1,915,069	1,932,394	0.618964	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	6,842	18,060,858	18,067,700	0.279503	95.00
200.00		Subtotal (see instructions)	194,623,071	351,899,281	546,522,352		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	194,623,071	351,899,281	546,522,352		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepared: 7/13/2020 7:28 am
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.254036		50.00
51.00	05100 RECOVERY ROOM	0.143734		51.00
53.00	05300 ANESTHESIOLOGY	0.036411		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.133582		54.00
56.00	05600 RADIOISOTOPE	0.317575		56.00
57.00	05700 CT SCAN	0.026910		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.100998		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.180667		59.00
60.00	06000 LABORATORY	0.140139		60.00
63.00	06300 BLOOD STORAGE, PROCESSING & TRANS.	0.266946		63.00
65.00	06500 RESPIRATORY THERAPY	0.255009		65.00
66.00	06600 PHYSICAL THERAPY	0.344628		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.384973		67.00
68.00	06800 SPEECH PATHOLOGY	0.353446		68.00
69.00	06900 ELECTROCARDIOLOGY	0.074533		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.376567		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.398878		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.443983		73.00
74.00	07400 RENAL DIALYSIS	0.417815		74.00
76.00	03020 ONCOLOGY & PAIN MANAGEMENT	0.326102		76.00
76.01	03340 GASTROINTESTINAL SERVICES	0.252893		76.01
76.02	03550 OP PSYCH	0.347994		76.02
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.109001		76.98
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0.087584		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.618964		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.279503		95.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

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

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet C
Part II
Date/Time Prepared:
7/13/2020 7:28 am

Cost Center Description		Title XIX			Hospital	PPS	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	11,290,597	1,232,617	10,057,980	0	0	50.00
51.00	05100 RECOVERY ROOM	1,218,698	132,306	1,086,392	0	0	51.00
53.00	05300 ANESTHESIOLOGY	411,946	36,401	375,545	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,974,904	1,061,743	4,913,161	0	0	54.00
56.00	05600 RADIOISOTOPE	770,689	125,764	644,925	0	0	56.00
57.00	05700 CT SCAN	1,175,322	228,304	947,018	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,181,949	141,089	1,040,860	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	1,908,175	269,547	1,638,628	0	0	59.00
60.00	06000 LABORATORY	6,801,358	837,131	5,964,227	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1,497,668	63,611	1,434,057	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	2,246,794	171,926	2,074,868	0	0	65.00
66.00	06600 PHYSICAL THERAPY	2,723,086	214,316	2,508,770	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	616,857	52,640	564,217	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	431,655	25,121	406,534	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	2,182,071	253,236	1,928,835	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,490,101	189,626	4,300,475	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	9,577,259	404,068	9,173,191	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	16,092,395	724,601	15,367,794	0	0	73.00
74.00	07400 RENAL DIALYSIS	560,560	24,214	536,346	0	0	74.00
76.00	03020 ONCOLOGY & PAIN MANAGEMENT	2,149,169	161,794	1,987,375	0	0	76.00
76.01	03340 GASTRO INTESTINAL SERVICES	2,131,312	177,775	1,953,537	0	0	76.01
76.02	03550 OP PSYCH	772,266	108,418	663,848	0	0	76.02
76.98	07698 HYPERBARIC OXYGEN THERAPY	271,235	9,728	261,507	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	7,258,093	639,454	6,618,639	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,196,082	117,102	1,078,980	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	5,049,983	585,473	4,464,510	0	0	95.00
200.00	Subtotal (sum of lines 50 thru 199)	89,980,224	7,988,005	81,992,219	0	0	200.00
201.00	Less Observation Beds	1,196,082	117,102	1,078,980	0	0	201.00
202.00	Total (Line 200 minus Line 201)	88,784,142	7,870,903	80,913,239	0	0	202.00

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

Provider CCN: 14-0002

Period: From 01/01/2019 To 12/31/2019

Worksheet C Part II Date/Time Prepared: 7/13/2020 7:28 am

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Title XIX	
					Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	11,290,597	44,444,837	0.254036		50.00
51.00	05100 RECOVERY ROOM	1,218,698	8,478,833	0.143734		51.00
53.00	05300 ANESTHESIOLOGY	411,946	11,313,779	0.036411		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,974,904	44,728,239	0.133582		54.00
56.00	05600 RADIOISOTOPE	770,689	2,426,791	0.317575		56.00
57.00	05700 CT SCAN	1,175,322	43,676,154	0.026910		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,181,949	11,702,672	0.100998		58.00
59.00	05900 CARDIAC CATHETERIZATION	1,908,175	10,561,834	0.180667		59.00
60.00	06000 LABORATORY	6,801,358	48,532,839	0.140139		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1,497,668	5,610,388	0.266946		63.00
65.00	06500 RESPIRATORY THERAPY	2,246,794	8,810,638	0.255009		65.00
66.00	06600 PHYSICAL THERAPY	2,723,086	7,901,512	0.344628		66.00
67.00	06700 OCCUPATIONAL THERAPY	616,857	1,602,339	0.384973		67.00
68.00	06800 SPEECH PATHOLOGY	431,655	1,221,276	0.353446		68.00
69.00	06900 ELECTROCARDIOLOGY	2,182,071	29,276,429	0.074533		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,490,101	11,923,764	0.376567		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	9,577,259	24,010,525	0.398878		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	16,092,395	36,245,520	0.443983		73.00
74.00	07400 RENAL DIALYSIS	560,560	1,341,648	0.417815		74.00
76.00	03020 ONCOLOGY & PAIN MANAGEMENT	2,149,169	6,590,477	0.326102		76.00
76.01	03340 GASTRO INTESTINAL SERVICES	2,131,312	8,427,711	0.252893		76.01
76.02	03550 OP PSYCH	772,266	2,219,191	0.347994		76.02
76.98	07698 HYPERBARIC OXYGEN THERAPY	271,235	2,488,380	0.109001		76.98
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	7,258,093	82,870,094	0.087584		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,196,082	1,932,394	0.618964		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	5,049,983	18,067,700	0.279503		95.00
200.00	Subtotal (sum of lines 50 thru 199)	89,980,224	476,405,964			200.00
201.00	Less Observation Beds	1,196,082	0			201.00
202.00	Total (line 200 minus line 201)	88,784,142	476,405,964			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part I Date/Time Prepared: 7/13/2020 7:28 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	
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,515,181	0	2,515,181	23,068	109.03	30.00
31.00	INTENSIVE CARE UNIT	310,353	0	310,353	2,283	135.94	31.00
40.00	SUBPROVIDER - IPF	259,857	0	259,857	2,112	123.04	40.00
43.00	NURSERY	56,059		56,059	1,689	33.19	43.00
200.00	Total (lines 30 through 199)	3,141,450		3,141,450	29,152		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	9,849	1,073,836				
31.00	INTENSIVE CARE UNIT	1,147	155,923				
40.00	SUBPROVIDER - IPF	1,649	202,893				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	12,645	1,432,652				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part II Date/Time Prepared: 7/13/2020 7:28 am
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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		
Title XVIII Hospital PPS								
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,232,617	44,444,837	0.027734	5,488,315	152,213	50.00
51.00	05100	RECOVERY ROOM	132,306	8,478,833	0.015604	784,226	12,237	51.00
53.00	05300	ANESTHESIOLOGY	36,401	11,313,779	0.003217	1,668,293	5,367	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,061,743	44,728,239	0.023738	1,807,368	42,903	54.00
56.00	05600	RADIOISOTOPE	125,764	2,426,791	0.051823	313,220	16,232	56.00
57.00	05700	CT SCAN	228,304	43,676,154	0.005227	4,957,670	25,914	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	141,089	11,702,672	0.012056	583,780	7,038	58.00
59.00	05900	CARDIAC CATHETERIZATION	269,547	10,561,834	0.025521	1,219,326	31,118	59.00
60.00	06000	LABORATORY	837,131	48,532,839	0.017249	9,858,725	170,053	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63,611	5,610,388	0.011338	547,043	6,202	63.00
65.00	06500	RESPIRATORY THERAPY	171,926	8,810,638	0.019513	3,958,330	77,239	65.00
66.00	06600	PHYSICAL THERAPY	214,316	7,901,512	0.027123	842,890	22,862	66.00
67.00	06700	OCCUPATIONAL THERAPY	52,640	1,602,339	0.032852	376,712	12,376	67.00
68.00	06800	SPEECH PATHOLOGY	25,121	1,221,276	0.020569	108,176	2,225	68.00
69.00	06900	ELECTROCARDIOLOGY	253,236	29,276,429	0.008650	6,001,910	51,917	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	189,626	11,923,764	0.015903	2,172,892	34,556	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	404,068	24,010,525	0.016829	4,361,804	73,405	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	724,601	36,245,520	0.019991	5,285,626	105,665	73.00
74.00	07400	RENAL DIALYSIS	24,214	1,341,648	0.018048	963,154	17,383	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	161,794	6,590,477	0.024550	3,351	82	76.00
76.01	03340	GASTROINTESTINAL SERVICES	177,775	8,427,711	0.021094	492,960	10,398	76.01
76.02	03550	OP PSYCH	108,418	2,219,191	0.048855	921	45	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	9,728	2,488,380	0.003909	3,216	13	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	639,454	82,870,094	0.007716	6,381,702	49,241	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	117,102	1,932,394	0.060599	5,010	304	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	7,402,532	458,338,264		58,186,620	926,988	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part III Date/Time Prepared: 7/13/2020 7:28 am
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Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	PPS
			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
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 cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	23,068	0.00	9,849	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	2,283	0.00	1,147	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	2,112	0.00	1,649	40.00
43.00	04300	NURSERY	0	0	1,689	0.00	0	43.00
200.00		Total (lines 30 through 199)	0	0	29,152		12,645	200.00
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost				
			9.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0				30.00
31.00	03100	INTENSIVE CARE UNIT	0	0				31.00
40.00	04000	SUBPROVIDER - IPF	0	0				40.00
43.00	04300	NURSERY	0	0				43.00
200.00		Total (lines 30 through 199)	0	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 7/13/2020 7:28 am
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Cost Center Description	Title XVIII			Hospital		PPS	
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
	1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0	0	0	0	76.00
76.01	03340	GASTROINTESTINAL SERVICES	0	0	0	0	76.01
76.02	03550	OP PSYCH	0	0	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 7/13/2020 7:28 am
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Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	44,444,837	0.000000	50.00
51.00 05100 RECOVERY ROOM	0	0	0	8,478,833	0.000000	51.00
53.00 05300 ANESTHESIOLOGY	0	0	0	11,313,779	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	44,728,239	0.000000	54.00
56.00 05600 RADIOISOTOPE	0	0	0	2,426,791	0.000000	56.00
57.00 05700 CT SCAN	0	0	0	43,676,154	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	11,702,672	0.000000	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	10,561,834	0.000000	59.00
60.00 06000 LABORATORY	0	0	0	48,532,839	0.000000	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	5,610,388	0.000000	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	8,810,638	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	7,901,512	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	1,602,339	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	1,221,276	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	29,276,429	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	11,923,764	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	24,010,525	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	36,245,520	0.000000	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	1,341,648	0.000000	74.00
76.00 03020 ONCOLOGY & PAIN MANAGEMENT	0	0	0	6,590,477	0.000000	76.00
76.01 03340 GASTROINTESTINAL SERVICES	0	0	0	8,427,711	0.000000	76.01
76.02 03550 OP PSYCH	0	0	0	2,219,191	0.000000	76.02
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	2,488,380	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0	0	0	82,870,094	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,932,394	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0	0	458,338,264		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 7/13/2020 7:28 am
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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	5,488,315	0	11,760,425	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	784,226	0	1,966,629	0	51.00
53.00	05300 ANESTHESIOLOGY	0.000000	1,668,293	0	2,017,307	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	1,807,368	0	12,212,604	0	54.00
56.00	05600 RADIOISOTOPE	0.000000	313,220	0	597,310	0	56.00
57.00	05700 CT SCAN	0.000000	4,957,670	0	10,038,212	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	583,780	0	3,368,280	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	1,219,326	0	1,725,647	0	59.00
60.00	06000 LABORATORY	0.000000	9,858,725	0	4,493,087	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	547,043	0	124,702	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.000000	3,958,330	0	548,963	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	842,890	0	14,694	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	376,712	0	5,076	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	108,176	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	6,001,910	0	8,421,197	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,172,892	0	1,850,529	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000	4,361,804	0	5,512,456	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	5,285,626	0	18,433,847	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	963,154	0	0	0	74.00
76.00	03020 ONCOLOGY & PAIN MANAGEMENT	0.000000	3,351	0	890,908	0	76.00
76.01	03340 GASTROINTESTINAL SERVICES	0.000000	492,960	0	2,066,271	0	76.01
76.02	03550 OP PSYCH	0.000000	921	0	1,835,820	0	76.02
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	3,216	0	1,458,456	0	76.98
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0.000000	6,381,702	0	11,270,705	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	5,010	0	574,319	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		58,186,620	0	101,187,444	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 7/13/2020 7:28 am
	Title XVIII	Hospital	PPS

Cost Center Description	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost	
	21.00	24.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00 05600 RADIOISOTOPE	0	0	56.00
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.00 03020 ONCOLOGY & PAIN MANAGEMENT	0	0	76.00
76.01 03340 GASTROINTESTINAL SERVICES	0	0	76.01
76.02 03550 OP PSYCH	0	0	76.02
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
OUTPATIENT SERVICE COST CENTERS			
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS			
95.00 09500 AMBULANCE SERVICES			95.00
200.00 Total (lines 50 through 199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prepared: 7/13/2020 7:28 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	0.254036	11,760,425	0	0	2,987,571	50.00
51.00	05100 RECOVERY ROOM	0.143734	1,966,629	0	0	282,671	51.00
53.00	05300 ANESTHESIOLOGY	0.036411	2,017,307	0	0	73,452	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.133582	12,212,604	0	0	1,631,384	54.00
56.00	05600 RADIOISOTOPE	0.317575	597,310	0	0	189,691	56.00
57.00	05700 CT SCAN	0.026910	10,038,212	0	0	270,128	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.100998	3,368,280	0	0	340,190	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.180667	1,725,647	0	0	311,767	59.00
60.00	06000 LABORATORY	0.140139	4,493,087	0	0	629,657	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.266946	124,702	0	0	33,289	63.00
65.00	06500 RESPIRATORY THERAPY	0.255009	548,963	0	0	139,991	65.00
66.00	06600 PHYSICAL THERAPY	0.344628	14,694	0	0	5,064	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.384973	5,076	0	0	1,954	67.00
68.00	06800 SPEECH PATHOLOGY	0.353446	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.074533	8,421,197	0	0	627,657	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.376567	1,850,529	0	0	696,848	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.398878	5,512,456	0	0	2,198,797	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.443983	18,433,847	0	23,151	8,184,315	73.00
74.00	07400 RENAL DIALYSIS	0.417815	0	0	0	0	74.00
76.00	03020 ONCOLOGY & PAIN MANAGEMENT	0.326102	890,908	0	0	290,527	76.00
76.01	03340 GASTRO INTESTINAL SERVICES	0.252893	2,066,271	0	0	522,545	76.01
76.02	03550 OP PSYCH	0.347994	1,835,820	0	0	638,854	76.02
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.109001	1,458,456	0	0	158,973	76.98
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0.087584	11,270,705	0	0	987,133	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.618964	574,319	0	0	355,483	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0.279503		0			95.00
200.00	Subtotal (see instructions)		101,187,444	0	23,151	21,557,941	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 - line 201)		101,187,444	0	23,151	21,557,941	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prepared: 7/13/2020 7:28 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
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	10,279	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03020 ONCOLOGY & PAIN MANAGEMENT	0	0	76.00
76.01	03340 GASTROINTESTINAL SERVICES	0	0	76.01
76.02	03550 OP PSYCH	0	0	76.02
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0	0	95.00
200.00	Subtotal (see instructions)	0	10,279	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00	Net Charges (line 200 - line 201)	0	10,279	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 14-0002 Component CCN: 14-S002		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part II Date/Time Prepared: 7/13/2020 7:28 am	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,232,617	44,444,837	0.027734	0	0	50.00
51.00	05100	RECOVERY ROOM	132,306	8,478,833	0.015604	0	0	51.00
53.00	05300	ANESTHESIOLOGY	36,401	11,313,779	0.003217	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,061,743	44,728,239	0.023738	32,371	768	54.00
56.00	05600	RADIOISOTOPE	125,764	2,426,791	0.051823	18	1	56.00
57.00	05700	CT SCAN	228,304	43,676,154	0.005227	115,755	605	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	141,089	11,702,672	0.012056	5,994	72	58.00
59.00	05900	CARDIAC CATHETERIZATION	269,547	10,561,834	0.025521	0	0	59.00
60.00	06000	LABORATORY	837,131	48,532,839	0.017249	182,074	3,141	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63,611	5,610,388	0.011338	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	171,926	8,810,638	0.019513	22,494	439	65.00
66.00	06600	PHYSICAL THERAPY	214,316	7,901,512	0.027123	13,313	361	66.00
67.00	06700	OCCUPATIONAL THERAPY	52,640	1,602,339	0.032852	2,405	79	67.00
68.00	06800	SPEECH PATHOLOGY	25,121	1,221,276	0.020569	2,080	43	68.00
69.00	06900	ELECTROCARDIOLOGY	253,236	29,276,429	0.008650	38,851	336	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	189,626	11,923,764	0.015903	23	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	404,068	24,010,525	0.016829	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	724,601	36,245,520	0.019991	67,961	1,359	73.00
74.00	07400	RENAL DIALYSIS	24,214	1,341,648	0.018048	0	0	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	161,794	6,590,477	0.024550	0	0	76.00
76.01	03340	GASTROINTESTINAL SERVICES	177,775	8,427,711	0.021094	0	0	76.01
76.02	03550	OP PSYCH	108,418	2,219,191	0.048855	1,543	75	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	9,728	2,488,380	0.003909	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	639,454	82,870,094	0.007716	240,538	1,856	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,932,394	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	7,285,430	458,338,264		725,420	9,135	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0002 Component CCN: 14-S002	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 7/13/2020 7:28 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00 03020 ONCOLOGY & PAIN MANAGEMENT	0	0	0	0	0	76.00
76.01 03340 GASTROINTESTINAL SERVICES	0	0	0	0	0	76.01
76.02 03550 OP PSYCH	0	0	0	0	0	76.02
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
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: 14-0002 Component CCN: 14-S002	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 7/13/2020 7:28 am
Title XVIII		Subprovider - IPF	PPS

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) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	44,444,837	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	8,478,833	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	11,313,779	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	44,728,239	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	2,426,791	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	43,676,154	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	11,702,672	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	10,561,834	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	48,532,839	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	5,610,388	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,810,638	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,901,512	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,602,339	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,221,276	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	29,276,429	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	11,923,764	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	24,010,525	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	36,245,520	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,341,648	0.000000	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0	0	0	6,590,477	0.000000	76.00
76.01	03340	GASTRO INTESTINAL SERVICES	0	0	0	8,427,711	0.000000	76.01
76.02	03550	OP PSYCH	0	0	0	2,219,191	0.000000	76.02
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	2,488,380	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	82,870,094	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,932,394	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	458,338,264		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 14-0002 Component CCN: 14-S002		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 7/13/2020 7:28 am	
				Title XVIII		Subprovider - IPF	PPS
Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	32,371	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	18	0	0	56.00
57.00	05700	CT SCAN	0.000000	115,755	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	5,994	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	182,074	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	22,494	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	13,313	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	2,405	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	2,080	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	38,851	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	23	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	67,961	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0.000000	0	0	0	76.00
76.01	03340	GASTROINTESTINAL SERVICES	0.000000	0	0	0	76.01
76.02	03550	OP PSYCH	0.000000	1,543	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.000000	240,538	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)		725,420	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0002 Component CCN: 14-S002	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 7/13/2020 7:28 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description			PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost	
			21.00	24.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0	0	76.00
76.01	03340	GASTROINTESTINAL SERVICES	0	0	76.01
76.02	03550	OP PSYCH	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (lines 50 through 199)	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part I Date/Time Prepared: 7/13/2020 7:28 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)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	2,515,181	0	2,515,181	23,068	109.03	30.00
31.00	INTENSIVE CARE UNIT	310,353	0	310,353	2,283	135.94	31.00
40.00	SUBPROVIDER - IPF	259,857	0	259,857	2,112	123.04	40.00
43.00	NURSERY	56,059		56,059	1,689	33.19	43.00
200.00	Total (lines 30 through 199)	3,141,450		3,141,450	29,152		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	805	87,769				
31.00	INTENSIVE CARE UNIT	117	15,905				
40.00	SUBPROVIDER - IPF	0	0				
43.00	NURSERY	220	7,302				
200.00	Total (lines 30 through 199)	1,142	110,976				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part II Date/Time Prepared: 7/13/2020 7:28 am
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Cost Center Description		Title XIX			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,232,617	44,444,837	0.027734	126,433	3,506	50.00
51.00	05100	RECOVERY ROOM	132,306	8,478,833	0.015604	17,015	266	51.00
53.00	05300	ANESTHESIOLOGY	36,401	11,313,779	0.003217	27,090	87	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,061,743	44,728,239	0.023738	103,631	2,460	54.00
56.00	05600	RADIOISOTOPE	125,764	2,426,791	0.051823	11,841	614	56.00
57.00	05700	CT SCAN	228,304	43,676,154	0.005227	312,709	1,635	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	141,089	11,702,672	0.012056	22,263	268	58.00
59.00	05900	CARDIAC CATHETERIZATION	269,547	10,561,834	0.025521	200,129	5,107	59.00
60.00	06000	LABORATORY	837,131	48,532,839	0.017249	617,116	10,645	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63,611	5,610,388	0.011338	118,959	1,349	63.00
65.00	06500	RESPIRATORY THERAPY	171,926	8,810,638	0.019513	58,185	1,135	65.00
66.00	06600	PHYSICAL THERAPY	214,316	7,901,512	0.027123	9,748	264	66.00
67.00	06700	OCCUPATIONAL THERAPY	52,640	1,602,339	0.032852	2,604	86	67.00
68.00	06800	SPEECH PATHOLOGY	25,121	1,221,276	0.020569	489	10	68.00
69.00	06900	ELECTROCARDIOLOGY	253,236	29,276,429	0.008650	200,311	1,733	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	189,626	11,923,764	0.015903	5,505	88	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	404,068	24,010,525	0.016829	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	724,601	36,245,520	0.019991	163,603	3,271	73.00
74.00	07400	RENAL DIALYSIS	24,214	1,341,648	0.018048	0	0	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	161,794	6,590,477	0.024550	0	0	76.00
76.01	03340	GASTROINTESTINAL SERVICES	177,775	8,427,711	0.021094	52,902	1,116	76.01
76.02	03550	OP PSYCH	108,418	2,219,191	0.048855	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	9,728	2,488,380	0.003909	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	639,454	82,870,094	0.007716	438,924	3,387	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	117,102	1,932,394	0.060599	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	7,402,532	458,338,264		2,489,457	37,027	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part III Date/Time Prepared: 7/13/2020 7:28 am
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Cost Center Description			Title XIX		Hospital		PPS	
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	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
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 cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	23,068	0.00	805	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	2,283	0.00	117	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	2,112	0.00	0	40.00
43.00	04300	NURSERY	0	0	1,689	0.00	220	43.00
200.00		Total (lines 30 through 199)	0	0	29,152		1,142	200.00
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost				
			9.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0				30.00
31.00	03100	INTENSIVE CARE UNIT	0	0				31.00
40.00	04000	SUBPROVIDER - IPF	0	0				40.00
43.00	04300	NURSERY	0	0				43.00
200.00		Total (lines 30 through 199)	0	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet D
Part IV
Date/Time Prepared:
7/13/2020 7:28 am

Cost Center Description		Title XIX			Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
		1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0	0	0	0	0	76.00
76.01	03340	GASTROINTESTINAL SERVICES	0	0	0	0	0	76.01
76.02	03550	OP PSYCH	0	0	0	0	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
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: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 7/13/2020 7:28 am
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Cost Center Description	Title XIX			Hospital	PPS	
	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	44,444,837	0.000000	50.00
51.00 05100 RECOVERY ROOM	0	0	0	8,478,833	0.000000	51.00
53.00 05300 ANESTHESIOLOGY	0	0	0	11,313,779	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	44,728,239	0.000000	54.00
56.00 05600 RADIOISOTOPE	0	0	0	2,426,791	0.000000	56.00
57.00 05700 CT SCAN	0	0	0	43,676,154	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	11,702,672	0.000000	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	10,561,834	0.000000	59.00
60.00 06000 LABORATORY	0	0	0	48,532,839	0.000000	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	5,610,388	0.000000	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	8,810,638	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	7,901,512	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	1,602,339	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	1,221,276	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	29,276,429	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	11,923,764	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	24,010,525	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	36,245,520	0.000000	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	1,341,648	0.000000	74.00
76.00 03020 ONCOLOGY & PAIN MANAGEMENT	0	0	0	6,590,477	0.000000	76.00
76.01 03340 GASTROINTESTINAL SERVICES	0	0	0	8,427,711	0.000000	76.01
76.02 03550 OP PSYCH	0	0	0	2,219,191	0.000000	76.02
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	2,488,380	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0	0	0	82,870,094	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,932,394	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0	0	0			95.00
200.00 Total (lines 50 through 199)	0	0	0	458,338,264		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet D
Part IV
Date/Time Prepared:
7/13/2020 7:28 am

Cost Center Description		Title XIX			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	126,433	0	0	0 50.00
51.00	05100	RECOVERY ROOM	0.000000	17,015	0	0	0 51.00
53.00	05300	ANESTHESIOLOGY	0.000000	27,090	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	103,631	0	0	0 54.00
56.00	05600	RADIOISOTOPE	0.000000	11,841	0	0	0 56.00
57.00	05700	CT SCAN	0.000000	312,709	0	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	22,263	0	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	200,129	0	0	0 59.00
60.00	06000	LABORATORY	0.000000	617,116	0	0	0 60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	118,959	0	0	0 63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	58,185	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	9,748	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	2,604	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	489	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	200,311	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	5,505	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	163,603	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0 74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0.000000	0	0	0	0 76.00
76.01	03340	GASTROINTESTINAL SERVICES	0.000000	52,902	0	0	0 76.01
76.02	03550	OP PSYCH	0.000000	0	0	0	0 76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0 76.98
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.000000	438,924	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)		2,489,457	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 7/13/2020 7:28 am
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Cost Center Description		PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost	Title XIX	Hospital	PPS
		21.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0			50.00
51.00	05100 RECOVERY ROOM	0	0			51.00
53.00	05300 ANESTHESIOLOGY	0	0			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0			54.00
56.00	05600 RADIOISOTOPE	0	0			56.00
57.00	05700 CT SCAN	0	0			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0			59.00
60.00	06000 LABORATORY	0	0			60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0			63.00
65.00	06500 RESPIRATORY THERAPY	0	0			65.00
66.00	06600 PHYSICAL THERAPY	0	0			66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0			67.00
68.00	06800 SPEECH PATHOLOGY	0	0			68.00
69.00	06900 ELECTROCARDIOLOGY	0	0			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0			73.00
74.00	07400 RENAL DIALYSIS	0	0			74.00
76.00	03020 ONCOLOGY & PAIN MANAGEMENT	0	0			76.00
76.01	03340 GASTROINTESTINAL SERVICES	0	0			76.01
76.02	03550 OP PSYCH	0	0			76.02
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0			76.98
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	0			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					95.00
200.00	Total (lines 50 through 199)	0	0			200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prepared: 7/13/2020 7:28 am
		Title XIX	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	0.254036	0	366,641	0	50.00
51.00	05100 RECOVERY ROOM	0.143734	0	54,959	0	51.00
53.00	05300 ANESTHESIOLOGY	0.036411	0	55,440	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.133582	0	1,055,706	0	54.00
56.00	05600 RADIOISOTOPE	0.317575	0	20,915	0	56.00
57.00	05700 CT SCAN	0.026910	0	732,987	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.100998	0	84,306	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.180667	0	50,589	0	59.00
60.00	06000 LABORATORY	0.140139	0	779,552	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.266946	0	135,927	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.255009	0	31,630	0	65.00
66.00	06600 PHYSICAL THERAPY	0.344628	0	107,784	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.384973	0	49,479	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.353446	0	50,720	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.074533	0	235,406	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.376567	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.398878	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.443983	0	641,704	0	73.00
74.00	07400 RENAL DIALYSIS	0.417815	0	0	0	74.00
76.00	03020 ONCOLOGY & PAIN MANAGEMENT	0.326102	0	60,431	0	76.00
76.01	03340 GASTRO INTESTINAL SERVICES	0.252893	0	12,793	0	76.01
76.02	03550 OP PSYCH	0.347994	0	593	0	76.02
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.109001	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0.087584	0	3,494,297	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.618964	0	115,784	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0.279503	0	684,071	0	95.00
200.00	Subtotal (see instructions)		0	8,821,714	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 - line 201)		0	8,821,714	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prepared: 7/13/2020 7:28 am
		Title XIX	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	93,140	0	50.00
51.00	05100 RECOVERY ROOM	7,899	0	51.00
53.00	05300 ANESTHESIOLOGY	2,019	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	141,023	0	54.00
56.00	05600 RADIOISOTOPE	6,642	0	56.00
57.00	05700 CT SCAN	19,725	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	8,515	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	9,140	0	59.00
60.00	06000 LABORATORY	109,246	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	36,285	0	63.00
65.00	06500 RESPIRATORY THERAPY	8,066	0	65.00
66.00	06600 PHYSICAL THERAPY	37,145	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	19,048	0	67.00
68.00	06800 SPEECH PATHOLOGY	17,927	0	68.00
69.00	06900 ELECTROCARDIOLOGY	17,546	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	284,906	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03020 ONCOLOGY & PAIN MANAGEMENT	19,707	0	76.00
76.01	03340 GASTRO INTESTINAL SERVICES	3,235	0	76.01
76.02	03550 OP PSYCH	206	0	76.02
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	306,045	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	71,666	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	191,200		95.00
200.00	Subtotal (see instructions)	1,410,331	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	1,410,331	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 7/13/2020 7:28 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)		23,068	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		23,068	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)		21,994	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		9,849	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)		25,690,133	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)		25,690,133	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)		25,690,133	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)		1,113.67	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		10,968,536	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)		10,968,536	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0002		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 7/13/2020 7:28 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)	
Title XVIII		1.00	2.00	3.00	4.00	5.00	
Hospital							
PPS							
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	4,651,067	2,283	2,037.26	1,147	2,336,737	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)					11,775,057	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					25,080,330	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)					1,229,759	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					926,988	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,156,747	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					22,923,583	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)					1,074	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,113.67	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,196,082	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0002		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 7/13/2020 7:28 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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,515,181	25,690,133	0.097905	1,196,082	117,102	90.00
91.00	Nursing School cost	0	25,690,133	0.000000	1,196,082	0	91.00
92.00	Allied health cost	0	25,690,133	0.000000	1,196,082	0	92.00
93.00	All other Medical Education	0	25,690,133	0.000000	1,196,082	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0002 Component CCN: 14-S002	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 7/13/2020 7:28 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,112	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,112	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)		2,112	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,649	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)		2,955,535	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)		2,955,535	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)		2,955,535	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)		1,399.40	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,307,611	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)		2,307,611	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0002 Component CCN: 14-S002		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 7/13/2020 7:28 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	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)					100,234	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,407,845	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)					202,893	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					9,135	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					212,028	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,195,817	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0002 Component CCN: 14-S002		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 7/13/2020 7:28 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	259,857	2,955,535	0.087922	0	0	90.00
91.00	Nursing School cost	0	2,955,535	0.000000	0	0	91.00
92.00	Allied health cost	0	2,955,535	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,955,535	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 7/13/2020 7:28 am
Cost Center Description		Title XIX	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)		23,068	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		23,068	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)		21,994	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		805	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)		1,689	15.00
16.00	Nursery days (title V or XIX only)		220	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)		25,690,133	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)		25,690,133	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)		25,690,133	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)		1,113.67	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		896,504	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)		896,504	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0002		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 7/13/2020 7:28 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)	PPS
Title XIX		1.00	2.00	3.00	4.00	5.00	
Hospital							
PPS							
42.00	NURSERY (title V & XIX only)	1,531,236	1,689	906.59	220	199,450	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	4,651,067	2,283	2,037.26	117	238,359	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)					379,047	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,713,360	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)					110,976	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					37,027	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					148,003	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,565,357	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)					1,074	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,113.67	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,196,082	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0002		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 7/13/2020 7:28 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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,515,181	25,690,133	0.097905	1,196,082	117,102	90.00
91.00	Nursing School cost	0	25,690,133	0.000000	1,196,082	0	91.00
92.00	Allied health cost	0	25,690,133	0.000000	1,196,082	0	92.00
93.00	All other Medical Education	0	25,690,133	0.000000	1,196,082	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 7/13/2020 7:28 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		21,490,503	30.00
31.00	03100	INTENSIVE CARE UNIT		5,650,654	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.254036	5,488,315	50.00
51.00	05100	RECOVERY ROOM	0.143734	784,226	51.00
53.00	05300	ANESTHESIOLOGY	0.036411	1,668,293	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.133582	1,807,368	54.00
56.00	05600	RADIOISOTOPE	0.317575	313,220	56.00
57.00	05700	CT SCAN	0.026910	4,957,670	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.100998	583,780	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.180667	1,219,326	59.00
60.00	06000	LABORATORY	0.140139	9,858,725	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.266946	547,043	63.00
65.00	06500	RESPIRATORY THERAPY	0.255009	3,958,330	65.00
66.00	06600	PHYSICAL THERAPY	0.344628	842,890	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.384973	376,712	67.00
68.00	06800	SPEECH PATHOLOGY	0.353446	108,176	68.00
69.00	06900	ELECTROCARDIOLOGY	0.074533	6,001,910	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.376567	2,172,892	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.398878	4,361,804	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.443983	5,285,626	73.00
74.00	07400	RENAL DIALYSIS	0.417815	963,154	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0.326102	3,351	76.00
76.01	03340	GASTROINTESTINAL SERVICES	0.252893	492,960	76.01
76.02	03550	OP PSYCH	0.347994	921	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.109001	3,216	76.98
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.087584	6,381,702	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.618964	5,010	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		58,186,620	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)		58,186,620	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0002 Component CCN: 14-S002	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 7/13/2020 7:28 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
40.00	04000 SUBPROVIDER - IPF		4,069,846	40.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.254036	0	50.00
51.00	05100 RECOVERY ROOM	0.143734	0	51.00
53.00	05300 ANESTHESIOLOGY	0.036411	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.133582	32,371	54.00
56.00	05600 RADIOISOTOPE	0.317575	18	56.00
57.00	05700 CT SCAN	0.026910	115,755	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.100998	5,994	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.180667	0	59.00
60.00	06000 LABORATORY	0.140139	182,074	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.266946	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.255009	22,494	65.00
66.00	06600 PHYSICAL THERAPY	0.344628	13,313	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.384973	2,405	67.00
68.00	06800 SPEECH PATHOLOGY	0.353446	2,080	68.00
69.00	06900 ELECTROCARDIOLOGY	0.074533	38,851	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.376567	23	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.398878	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.443983	67,961	73.00
74.00	07400 RENAL DIALYSIS	0.417815	0	74.00
76.00	03020 ONCOLOGY & PAIN MANAGEMENT	0.326102	0	76.00
76.01	03340 GASTROINTESTINAL SERVICES	0.252893	0	76.01
76.02	03550 OP PSYCH	0.347994	1,543	76.02
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.109001	0	76.98
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0.087584	240,538	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.618964	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES			95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		725,420	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)		725,420	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 7/13/2020 7:28 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		1,782,079	30.00
31.00	03100	INTENSIVE CARE UNIT		212,251	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
43.00	04300	NURSERY		400,331	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.254036	126,433	50.00
51.00	05100	RECOVERY ROOM	0.143734	17,015	51.00
53.00	05300	ANESTHESIOLOGY	0.036411	27,090	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.133582	103,631	54.00
56.00	05600	RADIOISOTOPE	0.317575	11,841	56.00
57.00	05700	CT SCAN	0.026910	312,709	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.100998	22,263	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.180667	200,129	59.00
60.00	06000	LABORATORY	0.140139	617,116	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.266946	118,959	63.00
65.00	06500	RESPIRATORY THERAPY	0.255009	58,185	65.00
66.00	06600	PHYSICAL THERAPY	0.344628	9,748	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.384973	2,604	67.00
68.00	06800	SPEECH PATHOLOGY	0.353446	489	68.00
69.00	06900	ELECTROCARDIOLOGY	0.074533	200,311	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.376567	5,505	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.398878	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.443983	163,603	73.00
74.00	07400	RENAL DIALYSIS	0.417815	0	74.00
76.00	03020	ONCOLOGY & PAIN MANAGEMENT	0.326102	0	76.00
76.01	03340	GASTROINTESTINAL SERVICES	0.252893	52,902	76.01
76.02	03550	OP PSYCH	0.347994	0	76.02
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.109001	0	76.98
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.087584	438,924	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.618964	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,489,457	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)		2,489,457	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 7/13/2020 7:28 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)		14,859,168	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		4,876,228	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		246,242	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		25,917	2.04
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		107.80	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.62	30.00
31.00	Percentage of Medicaid patient days (see instructions)		17.65	31.00
32.00	Sum of lines 30 and 31		22.27	32.00
33.00	Allowable disproportionate share percentage (see instructions)		7.59	33.00
34.00	Disproportionate share adjustment (see instructions)		374,480	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 7/13/2020 7:28 am
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		0	0 35.00
35.01	Factor 3 (see instructions)		0.000000000	0.000000000 35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		996,370	1,037,263 35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		745,230	260,733 35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,005,963	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
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		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	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	46.00
47.00	Subtotal (see instructions)		21,387,998	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00
				Amount
				1.00
49.00	Total payment for inpatient operating costs (see instructions)		21,387,998	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,695,430	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)		23,083,428	59.00
60.00	Primary payer payments		9,157	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		23,074,271	61.00
62.00	Deductibles billed to program beneficiaries		2,414,900	62.00
63.00	Coinurance billed to program beneficiaries		31,372	63.00
64.00	Allowable bad debts (see instructions)		646,194	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		420,026	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		469,732	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		21,048,025	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)		121,650	70.93
70.94	HRR adjustment amount (see instructions)		-396,685	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 7/13/2020 7:28 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		20,772,990	71.00
71.01	Sequestration adjustment (see instructions)		415,460	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		20,392,265	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-34,735	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,356,351	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. 1, 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	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	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	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.			
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. 11, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 14-0002		Period: From 01/01/2019 To 12/31/2019		Worksheet DSH	
		Title XVIII		Hospital		PPS	
		Original .mcx Values	Adjusted .mcx Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	4.62	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	17.65	0.00			17.65	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	22.27	0.00			17.65	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	Urban				Urban	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	107.80	0.00			107.80	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	7.59	0.00			0.00	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	Yes				No	9.00
10.00	S-2, Line 45	Yes				Yes	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	4.62	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	No				No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	870	0			870	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	544	0			544	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	26	0			26	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	24	0			24	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	2,654	0			2,654	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	466	0			466	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	4,584	0			4,584	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	25,966	0			25,966	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	0	0			0	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	25,966	0			25,966	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	17.65	0.00			17.65	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 14-0002		Period: From 01/01/2019 To 12/31/2019		Worksheet DSH Date/Time Prepared: 7/13/2020 7:28 am	
		Title XVIII		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	7.59		0.00	False	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	True	29.00
30.00	Line 28 or 29 as applicable		7.59		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		7.59		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
DETERMINATION OF PROVIDER TYPE							
32.00	Does the hospital qualify under the Pickle amendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet DSH Date/Time Prepared: 7/13/2020 7:28 am
		Title XVIII	Hospital	PPS

		Revised		
		Percentage		
		6.00		
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE				
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	0.00		28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	4.22		29.00
30.00	Line 28 or 29 as applicable	4.22		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	0.00		31.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 7/13/2020 7:28 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		10,279	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		21,557,941	2.00
3.00	OPPS payments		18,280,964	3.00
4.00	Outlier payment (see instructions)		10,993	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)		10,279	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		23,151	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)		23,151	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)		23,151	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		12,872	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)		10,279	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)		18,291,957	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)		3,349,610	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)		14,952,626	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)		14,952,626	30.00
31.00	Primary payer payments		10,576	31.00
32.00	Subtotal (line 30 minus line 31)		14,942,050	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)		436,533	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		283,746	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		288,199	36.00
37.00	Subtotal (see instructions)		15,225,796	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		15,225,796	40.00
40.01	Sequestration adjustment (see instructions)		304,516	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		15,067,447	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		-146,167	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 7/13/2020 7:28 am
Title XVIII		Hospital	PPS
WORKSHEET OVERRIDE VALUES			Overrides
			1.00
112.00 Override of Ancillary service charges (line 12)			0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet E-1
Part I
Date/Time Prepared:
7/13/2020 7:28 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		20,341,365		15,030,947	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	08/07/2019	50,900	08/07/2019	36,500	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)		50,900		36,500	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)		20,392,265		15,067,447	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		34,735		146,167	6.02	
7.00	Total Medicare program liability (see instructions)		20,357,530		14,921,280	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0002
Component CCN: 14-S002

Period:
From 01/01/2019
To 12/31/2019

Worksheet E-1
Part I
Date/Time Prepared:
7/13/2020 7:28 am
PPS

Title XVIII

Subprovider -
IPF

		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		1,417,400		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,417,400		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		17,614		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,435,014		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part II Date/Time Prepared: 7/13/2020 7:28 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
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0002 Component CCN: 14-S002	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part II Date/Time Prepared: 7/13/2020 7:28 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			1,524,162 1.00
2.00	Net IPF PPS Outlier Payments			29,897 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			5.786301 9.00
10.00	Teaching Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			1,554,059 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			1,554,059 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			1,554,059 18.00
19.00	Deductibles			103,640 19.00
20.00	Subtotal (line 18 minus line 19)			1,450,419 20.00
21.00	Coinsurance			4,092 21.00
22.00	Subtotal (line 20 minus line 21)			1,446,327 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			27,650 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			17,973 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			18,928 25.00
26.00	Subtotal (sum of lines 22 and 24)			1,464,300 26.00
27.00	Direct graduate medical education payments (see instructions)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			1,464,300 31.00
31.01	Sequestration adjustment (see instructions)			29,286 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			1,417,400 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			17,614 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			29,897 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

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

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet G

Date/Time Prepared:
7/13/2020 7:28 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	717,190	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	28,499,248	0	0	0	4.00
5.00	Other receivable	1,365,950	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-7,585,668	0	0	0	6.00
7.00	Inventory	2,280,450	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	447,137	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)	25,724,307	0	0	0	11.00
FIXED ASSETS						
12.00	Land	177,168	0	0	0	12.00
13.00	Land improvements	5,948,826	0	0	0	13.00
14.00	Accumulated depreciation	-4,768,968	0	0	0	14.00
15.00	Buildings	137,384,928	0	0	0	15.00
16.00	Accumulated depreciation	-87,010,436	0	0	0	16.00
17.00	Leasehold improvements	5,581,481	0	0	0	17.00
18.00	Accumulated depreciation	-655,830	0	0	0	18.00
19.00	Fixed equipment	1,086,031	0	0	0	19.00
20.00	Accumulated depreciation	-880,638	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	54,080,594	0	0	0	23.00
24.00	Accumulated depreciation	-43,884,882	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	1,948,959	0	0	0	27.00
28.00	Accumulated depreciation	-1,562,336	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	67,444,897	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	7,021,965	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	7,021,965	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	100,191,169	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	834,652	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,952,065	0	0	0	38.00
39.00	Payroll taxes payable	1,477,510	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	5,925,456	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	12,189,683	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	4,161,309	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	4,161,309	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	16,350,992	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	83,840,177				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)	83,840,177	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	100,191,169	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet G-1

Date/Time Prepared:
7/13/2020 7:28 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		78,209,150		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-6,970,148			2.00
3.00	Total (sum of line 1 and line 2)		71,239,002		0	3.00
4.00	TRANSFER FROM BJC	5,497,453		0		4.00
5.00	CHANGE IN RESTRICTED ASSETS	7,103,722		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		12,601,175		0	10.00
11.00	Subtotal (line 3 plus line 10)		83,840,177		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		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)		83,840,177		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	TRANSFER FROM BJC		0			4.00
5.00	CHANGE IN RESTRICTED ASSETS		0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet G-2
Parts I & II
Date/Time Prepared:
7/13/2020 7:28 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	55,242,780		55,242,780	1.00
2.00	SUBPROVIDER - IPF	5,258,587		5,258,587	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	60,501,367		60,501,367	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	10,580,045		10,580,045	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)	10,580,045		10,580,045	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	71,081,412		71,081,412	17.00
18.00	Ancillary services	122,691,684	336,565,191	459,256,875	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	6,842	18,060,058	18,066,900	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN REVENUE	0	10,098,244	10,098,244	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	193,779,938	364,723,493	558,503,431	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		153,701,543		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	NON OPERATING EXPENSES	915,328			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)		915,328		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		152,786,215		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0002

Period:
From 01/01/2019
To 12/31/2019

Worksheet G-3

Date/Time Prepared:
7/13/2020 7:28 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	558,503,431	1.00
2.00	Less contractual allowances and discounts on patients' accounts	407,485,610	2.00
3.00	Net patient revenues (line 1 minus line 2)	151,017,821	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	152,786,215	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,768,394	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	93,435	6.00
7.00	Income from investments	203,201	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	742,878	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	BJC OTHER OPERATING REVENUE	291,326	24.00
24.01	EUNICE SMITH NET INCOME	284,403	24.01
24.02	POB NET INCOME	406,857	24.02
24.03	OTHER OPERATING REVENUE	3,167,303	24.03
25.00	Total other income (sum of lines 6-24)	5,189,403	25.00
26.00	Total (line 5 plus line 25)	3,421,009	26.00
27.00	PHYSICIAN PRACTICE OPERATIONS	10,108,678	27.00
27.01	ACO OPERATIONS	282,479	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	10,391,157	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-6,970,148	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0002	Period: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III Date/Time Prepared: 7/13/2020 7:28 am
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,587,287	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		34,969	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)		66.51	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)		4.62	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		17.65	8.00
9.00	Sum of lines 7 and 8		22.27	9.00
10.00	Allowable disproportionate share percentage (see instructions)		4.61	10.00
11.00	Disproportionate share adjustment (see instructions)		73,174	11.00
12.00	Total prospective capital payments (see instructions)		1,695,430	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