

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: 14-0007	Period: From 07/01/2018 To 06/30/2019	Worksheet S Parts I-III Date/Time Prepared: 11/29/2019 8:41 am
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically filed cost report 2. ☐ Manually submitted cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report 4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.		

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 PRESENCE ST. JOSEPH MEDICAL CENTER (14-0007) for the cost reporting period beginning 07/01/2018 and ending 06/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) DEBORAH SCHIMEROWSKI
 Officer or Administrator of Provider(s)

REGIONAL CFO
 Title

(Dated when report is electronically signed.)
 Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	1,825,188	267,134	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	69,385	-170		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	1,894,573	266,964	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: 14-0007		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/29/2019 8:41 am		
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 333 NORTH MADISON STREET			PO Box:				1.00			
2.00	City: JOLIET			State: IL		Zip Code: 60435		County: KANE			
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
								V	XVIII	XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital			PRESENCE ST. JOSEPH MEDICAL CENTER	140007	20994	1	07/01/1966	N	P	O
4.00	Subprovider - IPF										
5.00	Subprovider - IRF			SJMC PHYSICAL MED & REHAB	14T007	20994	5	09/07/1987	N	P	O
6.00	Subprovider - (Other)										
7.00	Swing Beds - SNF										
8.00	Swing Beds - NF										
9.00	Hospital-Based SNF										
10.00	Hospital-Based NF										
11.00	Hospital-Based OLTC										
12.00	Hospital-Based HHA										
13.00	Separately Certified ASC										
14.00	Hospital-Based Hospice										
15.00	Hospital-Based Health Clinic - RHC										
16.00	Hospital-Based Health Clinic - FQHC										
17.00	Hospital-Based (CMHC) I										
18.00	Renal Dialysis										
19.00	Other										
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2018	06/30/2019		20.00	
21.00	Type of Control (see instructions)						1			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.					3	N		23.00		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	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.			2,488	2,116	16	87	10,355	795		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0007		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/29/2019 8:41 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.			175	121	0	6	402		25.00
							Urban/Rural S	Date of Geogr		
							1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						1			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						1			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0			35.00
							Beginning:	Ending:		
							1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.									36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.						0			37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)									37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.									38.00
							Y/N	Y/N		
							1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)						N	N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)						N	Y		40.00
							V	XVIII	XIX	
							1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital										
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)						N	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.						Y			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.						N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.						N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.						N			59.00
						NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
						1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)						Y			60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)							23.00	1	60.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0007

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part I
Date/Time Prepared:
11/29/2019 8:41 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0007

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part I
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			1.00	2.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
			1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS					
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.		N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					
					0	71.00
	Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.					
			Y			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					
			N	N	0	76.00

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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.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
Rural Providers				
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			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.			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: 14-0007	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part I Date/Time Prepared: 11/29/2019 8:41 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
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	6,592,356	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y		5.00	122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
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		14H082	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0007		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/29/2019 8:41 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: PRESENCE CARE TRANSFORMATION CORP		Contractor's Name: NGS		Contractor's Number: 00450				141.00	
142.00	Street: 200 SOUTH WACKER DRIVE		PO Box:						142.00	
143.00	City: CHICAGO		State: IL		Zip Code: 60606		143.00			
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?								Y	144.00
								1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				Y		145.00			
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N		146.00			
								1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital			N	N	N	N		155.00	
156.00	Subprovider - IPF			N	N	N	N		156.00	
157.00	Subprovider - IRF			N	N	N	N		157.00	
158.00	SUBPROVIDER								158.00	
159.00	SNF			N	N	N	N		159.00	
160.00	HOME HEALTH AGENCY			N	N	N	N		160.00	
161.00	CMHC				N	N	N		161.00	
								1.00		
Multicampus										
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00
				Name	County	State	Zip Code	CBSA	FTE/Campus	
				0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00	
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								9.99	169.00
						Beginning	Ending			
						1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)						07/01/2018	06/30/2019	170.00	
						1.00	2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N		0	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0007		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part II Date/Time Prepared: 11/29/2019 8:41 am	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			Y			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			Y			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.			Y			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.			Y			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			N		N	
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			Y	11/21/2019	Y	11/21/2019
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0007	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 11/29/2019 8:41 am
		Description	Y/N	Y/N
		0	1.00	3.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions			22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ANNE	LITTLE	41.00
42.00	Enter the employer/company name of the cost report preparer.	PRESENCE CARE TRANSFORMATION CORP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	847/813-3721	ANNE.LITTLE@AMITAHEALTH.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0007

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part II
Date/Time Prepared:
11/29/2019 8:41 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0007

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/29/2019 8:41 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	326	133,955	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)		326	133,955	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	33	12,045	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	34.00	24	8,760	0.00	0	11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		383	154,760	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	41	14,965		0	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)		424			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		9	3,285			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: 14-0007

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/29/2019 8:41 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	26,882	4,357	57,703			1.00
2.00	HMO and other (see instructions)	8,596	10,355				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	945	378				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)	26,882	4,357	57,703			7.00
8.00	INTENSIVE CARE UNIT	2,090	170	7,273			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT	1,809	75	4,812			11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		770	2,766			13.00
14.00	Total (see instructions)	30,781	5,372	72,554	5.00	1,353.00	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	8,771	326	12,004	0.00	57.00	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)			318			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)				5.00	1,410.00	27.00
28.00	Observation Bed Days		2,710	13,006			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)	1	130	326			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			426			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: 14-0007

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/29/2019 8:41 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	6,698	709	18,048	1.00
2.00 HMO and other (see instructions)			1,837	1,432		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				14		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	6,698	709	18,048	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	771	16	1,055	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: 14-0007

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part II
Date/Time Prepared:
11/29/2019 8:41 am

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	105,320,879	856,913	106,177,792	2,934,735.00	36.18	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		195,056	0	195,056	848.00	230.02	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	60,216	60,216	2,080.00	28.95	7.00
7.01	Contracted interns and residents (in an approved programs)		326,312	0	326,312	7,748.00	42.12	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		5,187,693	-195,056	4,992,637	142,077.00	35.14	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		15,895,264	0	15,895,264	379,835.00	41.85	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		960,951	0	960,951	6,652.00	144.46	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		32,533,842	0	32,533,842	776,460.00	41.90	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		22,326,334	0	22,326,334			17.00
18.00	Wage-related costs (other) (see instructions)		14,059	0	14,059			18.00
19.00	Excluded areas		943,078	0	943,078			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		9,700	0	9,700			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		1,778,933	0	1,778,933			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	-491,106	530,601	39,495	1,344.00	29.39	26.00
27.00	Administrative & General	5.00	7,030,418	-60,216	6,970,202	161,434.00	43.18	27.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0007

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part II
Date/Time Prepared:
11/29/2019 8:41 am

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		1,079,391	0	1,079,391	4,953.00	217.93	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,161,391	0	2,161,391	82,828.00	26.09	30.00
31.00	Laundry & Linen Service	8.00	79,203	0	79,203	5,068.00	15.63	31.00
32.00	Housekeeping	9.00	1,380,358	0	1,380,358	87,286.00	15.81	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	2,401,905	-1,188,822	1,213,083	78,702.00	15.41	34.00
35.00	Dietary under contract (see instructions)		1,264,519	0	1,264,519	29,083.00	43.48	35.00
36.00	Cafeteria	11.00	0	1,188,822	1,188,822	77,868.00	15.27	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	3,330,832	0	3,330,832	81,898.00	40.67	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	3,371,600	0	3,371,600	78,972.00	42.69	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0007

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part III
Date/Time Prepared:
11/29/2019 8:41 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	107,338,477	796,697	108,135,174	2,958,943.00	36.55	1.00
2.00	Excluded area salaries (see instructions)	5,187,693	-195,056	4,992,637	142,077.00	35.14	2.00
3.00	Subtotal salaries (line 1 minus line 2)	102,150,784	991,753	103,142,537	2,816,866.00	36.62	3.00
4.00	Subtotal other wages & related costs (see inst.)	49,390,057	0	49,390,057	1,162,947.00	42.47	4.00
5.00	Subtotal wage-related costs (see inst.)	24,129,026	0	24,129,026	0.00	23.39	5.00
6.00	Total (sum of lines 3 thru 5)	175,669,867	991,753	176,661,620	3,979,813.00	44.39	6.00
7.00	Total overhead cost (see instructions)	21,608,511	470,385	22,078,896	689,436.00	32.02	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0007	Period: From 07/01/2018 To 06/30/2019	Worksheet S-3 Part IV Date/Time Prepared: 11/29/2019 8:41 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			3,655,553 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)			340,098 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)			9,319,427 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			243,530 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			52,592 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)			304,831 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			1,490,910 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			7,530,671 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			138,179 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			203,323 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			23,279,114 24.00
Part B - Other than Core Related Cost				
25.00	EMPLOYEE ACTIVITIES			14,059 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0007

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part V
Date/Time Prepared:
11/29/2019 8:41 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	15,895,264	23,279,114	1.00
2.00	Hospital	15,895,264	22,441,580	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	837,534	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 RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

Provider CCN: 14-0007

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

Worksheet S-5

Date/Time Prepared:
11/29/2019 8:41 am

		Outpatient		Training		Home			
		Regular	High Flux	Hemodialysis	CAPD / CCPD	Hemodialysis	CAPD / CCPD		
		1.00	2.00	3.00	4.00	5.00	6.00		
1.00	Number of patients in program at end of cost reporting period	0	0	0	0	0	0	1.00	
2.00	Number of times per week patient receives dialysis	0.00	0.00	0.00	0.00	0.00	0.00	2.00	
3.00	Average patient dialysis time including setup	0.00	0.00	0.00	0.00			3.00	
4.00	CAPD exchanges per day				0.00		0.00	4.00	
5.00	Number of days in year dialysis furnished	0	0					5.00	
6.00	Number of stations	0	0	0	0			6.00	
7.00	Treatment capacity per day per station	0	0					7.00	
8.00	Utilization (see instructions)	0.00	0.00					8.00	
9.00	Average times dialyzers re-used	0.00	0.00					9.00	
10.00	Percentage of patients re-using dialyzers	0.00	0.00					10.00	
							Y/N		
							1.00		
ESRD PPS									
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter "Y" for yes or "N" for no. (see instructions)						N	10.01	
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter "Y" for yes or "N" for no. (See instructions for "new" providers.)						Y	10.02	
						Prior to 1/1	After 12/31		
						1.00	2.00		
10.03	If you responded "N" to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)						0	0	10.03
TRANSPLANT INFORMATION									
11.00	Number of patients on transplant list						0		11.00
12.00	Number of patients transplanted during the cost reporting period						0		12.00
EPOETIN									
13.00	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider.								13.00
14.00	Epoetin amount from Worksheet A for Home Dialysis program								14.00
15.00	Number of EPO units furnished relating to the renal dialysis department								15.00
16.00	Number of EPO units furnished relating to the home dialysis department								16.00
ARANESP									
17.00	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider.								17.00
18.00	ARANESP amount from Worksheet A for Home Dialysis program								18.00
19.00	Number of ARANESP units furnished relating to the renal dialysis department								19.00
20.00	Number of ARANESP units furnished relating to the home dialysis department								20.00
						MCP	INITIAL METHOD		
						1.00	2.00		
PHYSICIAN PAYMENT METHOD									
21.00	Enter "X" if method(s) is applicable								21.00
		ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.			
		1.00	2.00	3.00	4.00	5.00			
ESAs									
22.00	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)		0	0	0	0		22.00	

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

Provider CCN: 14-0007

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

Worksheet S-5

Date/Time Prepared:
11/29/2019 8:41 am

		CCN	Treatments	
		1.00	2.00	
23.00	If line 10.01 is yes, enter in column 1 the CCN for each renal dialysis facility listed on Worksheet S-2, Part I, line 18, and its subscripts. Enter in column 2, the total treatments for each CCN. (see instructions)		0	23.00

Health Financial Systems		PRESENCE ST. JOSEPH MEDICAL CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0007	Period: From 07/01/2018 To 06/30/2019	Worksheet S-10 Date/Time Prepared: 11/29/2019 8:41 am	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.162796	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			45,210,543	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?			Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			376,247,492	6.00
7.00	Medicaid cost (line 1 times line 6)			61,251,587	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)			16,041,044	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP			0	9.00
10.00	Stand-alone CHIP charges			0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			16,041,044	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)	34,484,004	7,114,374	41,598,378	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	5,613,858	7,114,374	12,728,232	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)	5,613,858	7,114,374	12,728,232	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)			9,619,437	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			1,567,027	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			2,410,812	27.01
28.00	Non-Medicare bad debt expense (see instructions)			7,208,625	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			2,017,320	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			14,745,552	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			30,786,596	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0007

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

Worksheet A

Date/Time Prepared:
11/29/2019 8:41 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	6,102,368	6,102,368	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	17,801,628	17,801,628	2.00
3.00	00300	OTHER CAP REL COSTS		374,543	374,543	-374,543	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-491,106	1,264,429	773,323	0	773,323	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,030,418	87,662,461	94,692,879	-9,482,116	85,210,763	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	2,161,391	14,147,553	16,308,944	-462,812	15,846,132	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	79,203	799,579	878,782	0	878,782	8.00
9.00	00900	HOUSEKEEPING	1,380,358	3,623,203	5,003,561	-87,088	4,916,473	9.00
10.00	01000	DIETARY	2,401,905	4,192,173	6,594,078	-3,187,989	3,406,089	10.00
11.00	01100	CAFETERIA	0	0	0	3,159,578	3,159,578	11.00
13.00	01300	NURSING ADMINISTRATION	3,330,832	1,708,201	5,039,033	-263,534	4,775,499	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	-274,295	-274,295	-9,932	-284,227	14.00
15.00	01500	PHARMACY	3,371,600	15,698,292	19,069,892	-14,660,220	4,409,672	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,166	2,166	-2,166	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	60,216	60,216	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	352,134	352,134	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	298,667	78,521	377,188	0	377,188	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	35,593,025	10,951,380	46,544,405	-5,260,089	41,284,316	30.00
31.00	03100	INTENSIVE CARE UNIT	4,494,662	1,398,567	5,893,229	-477,174	5,416,055	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	4,571,509	1,495,837	6,067,346	-525,493	5,541,853	34.00
41.00	04100	SUBPROVIDER - IRF	3,852,505	4,582,216	8,434,721	-2,566,999	5,867,722	41.00
43.00	04300	NURSERY	1,432,465	319,943	1,752,408	1,020,660	2,773,068	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,604,363	37,563,241	48,167,604	-25,983,446	22,184,158	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,126,773	2,126,773	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,357,183	3,465,356	7,822,539	-1,996,296	5,826,243	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	428,212	664,736	1,092,948	-317,698	775,250	55.00
56.00	05600	RADIOISOTOPE	2,001,403	4,700,762	6,702,165	-3,977,991	2,724,174	56.00
57.00	05700	CT SCAN	905,125	923,938	1,829,063	-422,867	1,406,196	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	538,413	1,001,552	1,539,965	-657,981	881,984	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,689,103	10,188,912	12,878,015	-9,552,769	3,325,246	59.00
60.00	06000	LABORATORY	0	13,674,956	13,674,956	-197,835	13,477,121	60.00
64.00	06400	INTRAVENOUS THERAPY	608,240	173,567	781,807	-26,747	755,060	64.00
65.00	06500	RESPIRATORY THERAPY	2,521,319	1,375,706	3,897,025	-590,013	3,307,012	65.00
66.00	06600	PHYSICAL THERAPY	145,658	9,499,203	9,644,861	2,025,037	11,669,898	66.00
69.00	06900	ELECTROCARDIOLOGY	1,083,763	630,169	1,713,932	-336,434	1,377,498	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	252,292	96,883	349,175	-20,683	328,492	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	24,802,362	24,802,362	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	18,039,475	18,039,475	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	14,653,219	14,653,219	73.00
74.00	07400	RENAL DIALYSIS	688,526	509,458	1,197,984	-135,017	1,062,967	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	119,877	25,316	145,193	-475	144,718	76.10
76.97	07697	CARDIAC REHABILITATION	470,366	108,801	579,167	-7,977	571,190	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	7,363,081	4,316,577	11,679,658	-873,377	10,806,281	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		7,260,862	7,260,862	-7,260,862	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	104,284,358	244,204,764	348,489,122	424,827	348,913,949	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	OTHER NRCC	1,036,521	2,801,692	3,838,213	-424,827	3,413,386	192.01
200.00		TOTAL (SUM OF LINES 118 through 199)	105,320,879	247,006,456	352,327,335	0	352,327,335	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0007

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

Worksheet A

Date/Time Prepared:
11/29/2019 8:41 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,015,851	7,118,219	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-10,284	17,791,344	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,099,920	1,873,243	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-15,204,522	70,006,241	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-86,704	15,759,428	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,226	884,008	8.00
9.00	00900	HOUSEKEEPING	0	4,916,473	9.00
10.00	01000	DIETARY	0	3,406,089	10.00
11.00	01100	CAFETERIA	-1,320,975	1,838,603	11.00
13.00	01300	NURSING ADMINISTRATION	-7,393	4,768,106	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,053,433	1,769,206	14.00
15.00	01500	PHARMACY	-13,180	4,396,492	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,913,006	1,913,006	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	60,216	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	-2,238	349,896	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	377,188	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-381,212	40,903,104	30.00
31.00	03100	INTENSIVE CARE UNIT	867,902	6,283,957	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	5,541,853	34.00
41.00	04100	SUBPROVIDER - IRF	-67,560	5,800,162	41.00
43.00	04300	NURSERY	-156,516	2,616,552	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-3,285,001	18,899,157	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-294,854	1,831,919	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-3,016	5,823,227	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	775,250	55.00
56.00	05600	RADIOISOTOPE	0	2,724,174	56.00
57.00	05700	CT SCAN	0	1,406,196	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	881,984	58.00
59.00	05900	CARDIAC CATHETERIZATION	-31,671	3,293,575	59.00
60.00	06000	LABORATORY	199,368	13,676,489	60.00
64.00	06400	INTRAVENOUS THERAPY	-13	755,047	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,307,012	65.00
66.00	06600	PHYSICAL THERAPY	-253,403	11,416,495	66.00
69.00	06900	ELECTROCARDIOLOGY	-7,439	1,370,059	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	328,492	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	24,802,362	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	18,039,475	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-3,031	14,650,188	73.00
74.00	07400	RENAL DIALYSIS	-2,238	1,060,729	74.00
76.00	03950	OTHER ANCILLARY	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	144,718	76.10
76.97	07697	CARDIAC REHABILITATION	-48,739	522,451	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-1,342,115	9,464,166	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-15,367,398	333,546,551	118.00
NONREIMBURSABLE COST CENTERS					
192.01	19201	OTHER NRCC	0	3,413,386	192.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-15,367,398	336,959,937	200.00

RECLASSIFICATIONS

Provider CCN: 14-0007

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

Worksheet A-6

Date/Time Prepared:
11/29/2019 8:41 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS CAFETERIA COSTS					
1.00	CAFETERIA	11.00	1,188,822	1,970,756		1.00
	0		1,188,822	1,970,756		
	B - SHARED RADIOLOFY					
1.00	RADIOLOGY - THERAPEUTIC	55.00	50,497	22,610		1.00
2.00	RADIOISOTOPE	56.00	236,015	30,668		2.00
3.00	CT SCAN	57.00	106,737	20,877		3.00
4.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	63,492	19,379		4.00
	0		456,741	93,534		
	C - RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,792,517		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5,468,345		2.00
	0		0	7,260,862		
	D - RECLASS MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	24,802,362		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	18,039,475		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
	0		0	42,841,837		
	E - RECLASS DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,016,290		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	12,252,301		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00

RECLASSIFICATIONS

Provider CCN: 14-0007

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

Worksheet A-6

Date/Time Prepared:
11/29/2019 8:41 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35.00
36.00		0.00	0	0		36.00
37.00		0.00	0	0		37.00
38.00		0.00	0	0		38.00
39.00		0.00	0	0		39.00
40.00		0.00	0	0		40.00
41.00		0.00	0	0		41.00
42.00		0.00	0	0		42.00
43.00		0.00	0	0		43.00
44.00		0.00	0	0		44.00
45.00		0.00	0	0		45.00
46.00		0.00	0	0		46.00
47.00		0.00	0	0		47.00
48.00		0.00	0	0		48.00
49.00		0.00	0	0		49.00
50.00		0.00	0	0		50.00
51.00		0.00	0	0		51.00
52.00		0.00	0	0		52.00
53.00		0.00	0	0		53.00
54.00		0.00	0	0		54.00
55.00		0.00	0	0		55.00
56.00		0.00	0	0		56.00
57.00		0.00	0	0		57.00
58.00		0.00	0	0		58.00
59.00		0.00	0	0		59.00
60.00		0.00	0	0		60.00
61.00		0.00	0	0		61.00
62.00		0.00	0	0		62.00
63.00		0.00	0	0		63.00
64.00		0.00	0	0		64.00
65.00		0.00	0	0		65.00
			0	16,268,591		
	F - EMPLOYEE BENEFIT RECLASSIFICATION					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	530,601	0		1.00
	TOTALS		530,601	0		
	H - RECLASS MEDICAL DIRECTOR FEES					
1.00	OPERATING ROOM	50.00	169,775	11,825		1.00
2.00	NURSERY	43.00	25,281	0		2.00
			195,056	11,825		
	I - LDR RECLASS					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	1,584,557	542,216		1.00
2.00	NURSERY	43.00	784,321	268,385		2.00
			2,368,878	810,601		
	J - PHARMACY RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	14,653,219		1.00
	TOTALS		0	14,653,219		
	K - REHAB CARE RECLASSIFICATION					
1.00	PHYSICAL THERAPY	66.00	0	2,398,643		1.00
	TOTALS		0	2,398,643		
	L - INTERN RECLASS					
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	60,216	0		1.00
2.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	326,312	13,822		2.00
3.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	12,000		3.00
	TOTALS		386,528	25,822		
500.00	Grand Total: Increases		5,126,626	86,335,690		500.00

RECLASSIFICATIONS

Provider CCN: 14-0007

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

Worksheet A-6

Date/Time Prepared:
11/29/2019 8:41 am

	Decreases						11/29/2019 8:41 am
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS CAFETERIA COSTS						
1.00	DIETARY	10.00	1,188,822	1,970,756	0		1.00
	0		1,188,822	1,970,756			
	B - SHARED RADIOLOGY						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	50,497	22,610	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	236,015	30,668	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	106,737	20,877	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	63,492	19,379	0		4.00
	0		456,741	93,534			
	C - RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	1,792,517	11		1.00
2.00	INTEREST EXPENSE	113.00	0	5,468,345	11		2.00
	0		0	7,260,862			
	D - RECLASS MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	1,932,808	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	419,595	0		2.00
3.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	516,644	0		3.00
4.00	SUBPROVIDER - IRF	41.00	0	164,141	0		4.00
5.00	NURSERY	43.00	0	47,028	0		5.00
6.00	OPERATING ROOM	50.00	0	24,758,558	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	203,525	0		7.00
8.00	RADIOLOGY - THERAPEUTIC	55.00	0	4,854	0		8.00
9.00	RADIOISOTOPE	56.00	0	3,808,139	0		9.00
10.00	CT SCAN	57.00	0	101,118	0		10.00
11.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	30,082	0		11.00
12.00	CARDIAC CATHETERIZATION	59.00	0	8,908,055	0		12.00
13.00	LABORATORY	60.00	0	51,356	0		13.00
14.00	INTRAVENOUS THERAPY	64.00	0	26,747	0		14.00
15.00	RESPIRATORY THERAPY	65.00	0	516,158	0		15.00
16.00	PHYSICAL THERAPY	66.00	0	351,235	0		16.00
17.00	ELECTROCARDIOLOGY	69.00	0	29,196	0		17.00
18.00	ELECTROENCEPHALOGRAPHY	70.00	0	19,361	0		18.00
19.00	RENAL DIALYSIS	74.00	0	123,190	0		19.00
20.00	OUTPATIENT PSYCH	76.10	0	475	0		20.00
21.00	CARDIAC REHABILITATION	76.97	0	3,024	0		21.00
22.00	EMERGENCY	91.00	0	826,548	0		22.00
	0		0	42,841,837			
	E - RECLASS DEPRECIATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	9,069,766	9		1.00
2.00	OPERATION OF PLANT	7.00	0	462,812	9		2.00
3.00	HOUSEKEEPING	9.00	0	87,088	9		3.00
4.00	DIETARY	10.00	0	28,411	9		4.00
5.00	NURSING ADMINISTRATION	13.00	0	263,534	9		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	9,932	9		6.00
7.00	PHARMACY	15.00	0	7,001	9		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,166	9		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	147,802	9		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	57,579	9		10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	8,849	9		11.00
12.00	SUBPROVIDER - IRF	41.00	0	4,215	9		12.00
13.00	NURSERY	43.00	0	10,299	9		13.00
14.00	OPERATING ROOM	50.00	0	1,406,488	9		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,242,496	9		15.00
16.00	RADIOLOGY - THERAPEUTIC	55.00	0	385,951	9		16.00
17.00	RADIOISOTOPE	56.00	0	436,535	9		17.00
18.00	CT SCAN	57.00	0	449,363	9		18.00
19.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	710,770	9		19.00
20.00	CARDIAC CATHETERIZATION	59.00	0	644,714	9		20.00
21.00	LABORATORY	60.00	0	146,479	9		21.00
22.00	RESPIRATORY THERAPY	65.00	0	73,855	9		22.00
23.00	PHYSICAL THERAPY	66.00	0	22,371	9		23.00
24.00	ELECTROCARDIOLOGY	69.00	0	307,238	9		24.00
25.00	ELECTROENCEPHALOGRAPHY	70.00	0	1,322	9		25.00
26.00	RENAL DIALYSIS	74.00	0	11,827	9		26.00
27.00	CARDIAC REHABILITATION	76.97	0	4,953	9		27.00
28.00	EMERGENCY	91.00	0	46,829	9		28.00
29.00	OTHER NRCC	192.01	0	217,946	9		29.00
30.00		0.00	0	0	9		30.00
31.00		0.00	0	0	9		31.00
32.00		0.00	0	0	9		32.00
33.00		0.00	0	0	9		33.00
34.00		0.00	0	0	9		34.00

RECLASSIFICATIONS

Provider CCN: 14-0007

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

Worksheet A-6

Date/Time Prepared:
11/29/2019 8:41 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
35.00		0.00	0	0	9		35.00
36.00		0.00	0	0	9		36.00
37.00		0.00	0	0	9		37.00
38.00		0.00	0	0	9		38.00
39.00		0.00	0	0	9		39.00
40.00		0.00	0	0	9		40.00
41.00		0.00	0	0	9		41.00
42.00		0.00	0	0	9		42.00
43.00		0.00	0	0	9		43.00
44.00		0.00	0	0	9		44.00
45.00		0.00	0	0	9		45.00
46.00		0.00	0	0	9		46.00
47.00		0.00	0	0	9		47.00
48.00		0.00	0	0	9		48.00
49.00		0.00	0	0	9		49.00
50.00		0.00	0	0	9		50.00
51.00		0.00	0	0	9		51.00
52.00		0.00	0	0	9		52.00
53.00		0.00	0	0	9		53.00
54.00		0.00	0	0	9		54.00
55.00		0.00	0	0	9		55.00
56.00		0.00	0	0	9		56.00
57.00		0.00	0	0	9		57.00
58.00		0.00	0	0	9		58.00
59.00		0.00	0	0	9		59.00
60.00		0.00	0	0	9		60.00
61.00		0.00	0	0	9		61.00
62.00		0.00	0	0	9		62.00
63.00		0.00	0	0	9		63.00
64.00		0.00	0	0	9		64.00
65.00		0.00	0	0	9		65.00
	0		0	16,268,591			
	F - EMPLOYEE BENEFIT RECLASSIFICATION						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	530,601	0		1.00
	TOTALS		0	530,601			
	H - RECLASS MEDICAL DIRECTOR FEES						
1.00	OTHER NRCC	192.01	169,775	11,825	0		1.00
2.00	OTHER NRCC	192.01	25,281	0	0		2.00
	0		195,056	11,825			
	I - LDR RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	1,584,557	542,216	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	784,321	268,385	0		2.00
	0		2,368,878	810,601			
	J - PHARMACY RECLASS						
1.00	PHARMACY	15.00	0	14,653,219	0		1.00
	TOTALS		0	14,653,219			
	K - REHAB CARE RECLASSIFICATION						
1.00	SUBPROVIDER - IRF	41.00	0	2,398,643	0		1.00
	TOTALS		0	2,398,643			
	L - INTERN RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	60,216	340,134	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	12,000	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		60,216	352,134			
500.00	Grand Total: Decreases		4,269,713	87,192,603			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0007

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part I
Date/Time Prepared:
11/29/2019 8:41 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	7,950,000	0	0	0	0	1.00	
2.00	Land Improvements	1,188,596	0	0	0	0	2.00	
3.00	Buildings and Fixtures	92,256,381	5,161,349	0	5,161,349	881,305	3.00	
4.00	Building Improvements	3,702,141	3,659,727	0	3,659,727	6,721,187	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	24,289,789	4,801,432	0	4,801,432	2,773,417	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	129,386,907	13,622,508	0	13,622,508	10,375,909	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	129,386,907	13,622,508	0	13,622,508	10,375,909	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	7,950,000	0				1.00	
2.00	Land Improvements	1,188,596	0				2.00	
3.00	Buildings and Fixtures	96,536,425	0				3.00	
4.00	Building Improvements	640,681	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	26,317,804	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	132,633,506	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	132,633,506	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0007

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part II
Date/Time Prepared:
11/29/2019 8:41 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	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	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	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: 14-0007

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part III
Date/Time Prepared:
11/29/2019 8:41 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	97,725,021	0	97,725,021	0.783785	293,561	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	26,958,485	0	26,958,485	0.216215	80,982	2.00
3.00	Total (sum of lines 1-2)	124,683,506	0	124,683,506	1.000000	374,543	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	293,561	6,824,658	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	80,982	17,710,362	0	2.00
3.00	Total (sum of lines 1-2)	0	0	374,543	24,535,020	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	293,561	0	0	7,118,219	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	80,982	0	0	17,791,344	2.00
3.00	Total (sum of lines 1-2)	0	374,543	0	0	24,909,563	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0007

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

Worksheet A-8

Date/Time Prepared:
11/29/2019 8:41 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-66,460	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-202,747	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-86,704	OPERATION OF PLANT	7.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-6,847,321			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	-11,226,111			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-1,320,975	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	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	2,808,368	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	3,824,733	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME	B	-3,016	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0007

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

Worksheet A-8

Date/Time Prepared:
11/29/2019 8:41 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00	2.00	3.00	4.00	5.00			
34.00	MISC INCOME	B	-313,476	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.00
36.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	36.00
37.00	MISC INCOME	B	-5,155	NURSING ADMINISTRATION	13.00	0	37.00
38.00	MISC INCOME	B	-13,180	PHARMACY	15.00	0	38.00
39.00	UNCLAIMED PROPERTY EXEMPTIONS	B	-420	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	MISC INCOME	B	-29,800	ADULTS & PEDIATRICS	30.00	0	40.00
41.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	41.00
42.00	MISC INCOME	B	-75	RADIOLOGY-DIAGNOSTIC	54.00	0	42.00
42.01	MISC INCOME	B	-1,900	DELIVERY ROOM & LABOR ROOM	52.00	0	42.01
43.00	MISC INCOME	B	-28,458	LABORATORY	60.00	0	43.00
44.00	MISC INCOME	B	-17,775	PHYSICAL THERAPY	66.00	0	44.00
44.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.01
44.02	MISC INCOME	B	-48,739	CARDIAC REHABILITATION	76.97	0	44.02
44.03	INTERCOMPANY RENTAL INCOME	B	-634,713	ADMINISTRATIVE & GENERAL	5.00	0	44.03
45.00	RENTAL INCOME	B	-152,550	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01	MISC INCOME	B	-2,115	OPERATING ROOM	50.00	0	45.01
45.02	MISC INCOME	B	-3,906	EMERGENCY	91.00	0	45.02
45.03	MARKETING AND ADVERTISING	A	-26,096	ADMINISTRATIVE & GENERAL	5.00	0	45.03
46.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	46.00
46.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	46.01
46.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	46.02
46.03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	46.03
47.01	CONTRIBUTIONS CHARITABLE	A	-433,658	ADMINISTRATIVE & GENERAL	5.00	0	47.01
48.00	PATIENT TRANSPORTATION	A	-235,628	PHYSICAL THERAPY	66.00	0	48.00
48.01	INCOME AND REAL ESTATE TAX	A	-54,477	ADMINISTRATIVE & GENERAL	5.00	0	48.01
48.02	CBISA CONTRIBUTION	A	-213,451	ADMINISTRATIVE & GENERAL	5.00	0	48.02
48.03	INVESTMENT INCOME MEDICAL STAFF	B	-31,443	ADMINISTRATIVE & GENERAL	5.00	0	48.03
48.04	ALCOHOL PURCHASE	A	-150	ADMINISTRATIVE & GENERAL	5.00	0	48.04
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-15,367,398				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: 14-0007

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

Worksheet A-8-1

Date/Time Prepared:
11/29/2019 8:41 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		2.00	CAP REL COSTS-MVBLE EQUIP	DIRECT RENTAL EXPENSE	247,725	0 1.00
2.00		5.00	ADMINISTRATIVE & GENERAL	DIRECT ADM & GENERAL	1,391,559	0 2.00
3.00		14.00	CENTRAL SERVICES & SUPPLY	DIRECT CENTRAL SUPPLY	1,747,329	0 3.00
3.01		5.00	ADMINISTRATIVE & GENERAL	PRESENCE ABHS ALLOCATION	7,209,865	0 3.01
3.02		5.00	ADMINISTRATIVE & GENERAL	NATIONAL OFFICE ALLOCATION	-357,536	0 3.02
3.03		5.00	ADMINISTRATIVE & GENERAL	FUNCTIONAL ADMIN & GENERAL	24,023,140	43,982,710 3.03
3.04		31.00	INTENSIVE CARE UNIT	TELE ICU	1,044,902	0 3.04
3.05		16.00	MEDICAL RECORDS & LIBRARY	EMR & CODERS & HIM	1,913,006	0 3.05
3.06		4.00	EMPLOYEE BENEFITS DEPARTMENT	HUMAN RESOURCES	1,102,936	0 3.06
3.07		8.00	LAUNDRY & LINEN SERVICE	LAUNDRY	5,226	0 3.07
3.08		14.00	CENTRAL SERVICES & SUPPLY	MATERIALS MANAGEMENT	306,104	0 3.08
3.09		2.00	CAP REL COSTS-MVBLE EQUIP	POOLED CAPITAL	344,167	0 3.09
3.10		5.00	ADMINISTRATIVE & GENERAL	POOLED NON CAPITAL	-508,941	0 3.10
3.11		1.00	CAP REL COSTS-BLDG & FIXT	FUNCTIONAL INTEREST EXPENSE	973,888	0 3.11
3.12		2.00	CAP REL COSTS-MVBLE EQUIP	FUNCTIONAL INTEREST EXPENSE	2,970,992	0 3.12
3.13		1.00	CAP REL COSTS-BLDG & FIXT	FUNCTIONAL INTEREST INCOME	-2,699,945	0 3.13
3.14		2.00	CAP REL COSTS-MVBLE EQUIP	FUNCTIONAL INTEREST INCOME	-8,236,590	0 3.14
3.15		2.00	CAP REL COSTS-MVBLE EQUIP	FUNCTIONAL RENTAL EXPENSE	1,041,436	0 3.15
3.16		0.00			0	0 3.16
3.17		0.00			0	0 3.17
3.18		0.00			0	0 3.18
4.00		60.00	LABORATORY	PURCHASE FEE	12,336,333	12,098,997 4.00
5.00			TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.		44,855,596	56,081,707 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		
Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
1.00	2.00	3.00	4.00	5.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	B	PRESENCE CARE	100.00		0.00	6.00
7.00	C	APHL LABS	66.67		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-0007

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

Worksheet A-8-1

Date/Time Prepared:
11/29/2019 8:41 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	247,725	9		1.00
2.00	1,391,559	0		2.00
3.00	1,747,329	0		3.00
3.01	7,209,865	0		3.01
3.02	-357,536	0		3.02
3.03	-19,959,570	9		3.03
3.04	1,044,902	0		3.04
3.05	1,913,006	0		3.05
3.06	1,102,936	9		3.06
3.07	5,226	0		3.07
3.08	306,104	0		3.08
3.09	344,167	9		3.09
3.10	-508,941	0		3.10
3.11	973,888	11		3.11
3.12	2,970,992	11		3.12
3.13	-2,699,945	11		3.13
3.14	-8,236,590	11		3.14
3.15	1,041,436	9		3.15
3.16	0	0		3.16
3.17	0	0		3.17
3.18	0	0		3.18
4.00	237,336	0		4.00
5.00	-11,226,111			5.00

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

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0007

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

Worksheet A-8-2

Date/Time Prepared:
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	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	1,541,041	968,566	572,475	211,500	4,146	1.00
2.00	13.00	NURSING ADMINISTRATION	12,000	0	12,000	211,500	96	2.00
3.00	50.00	OPERATING ROOM	1,200,000	1,200,000	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	133,627	107,027	26,600	211,500	200	4.00
5.00	31.00	INTENSIVE CARE UNIT	177,000	177,000	0	211,500	0	5.00
6.00	41.00	SUBPROVIDER - IRF	113,826	0	113,826	211,500	455	6.00
7.00	50.00	OPERATING ROOM	2,176,589	1,985,339	191,250	246,400	791	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	20,196	0	20,196	271,900	132	8.00
9.00	60.00	LABORATORY	39,545	3,545	36,000	260,300	240	9.00
10.00	65.00	RESPIRATORY THERAPY	30,000	0	30,000	211,500	300	10.00
11.00	69.00	ELECTROCARDIOLOGY	23,200	0	23,200	211,500	155	11.00
12.00	91.00	EMERGENCY	1,374,103	1,329,949	44,154	211,500	353	12.00
13.00	74.00	RENAL DIALYSIS	12,000	0	12,000	211,500	96	13.00
14.00	52.00	DELIVERY ROOM & LABOR ROOM	292,954	292,954	0	0	0	14.00
15.00	59.00	CARDIAC CATHETERIZATION	47,545	27,495	20,050	246,400	134	15.00
16.00	73.00	DRUGS CHARGED TO PATIENTS	16,250	0	16,250	211,500	130	16.00
17.00	43.00	NURSERY	25,281	0	25,281	169,700	169	17.00
18.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	12,000	0	12,000	211,500	96	18.00
19.00	64.00	INTRAVENOUS THERAPY	725	0	725	211,500	7	19.00
20.00	30.00	ADULTS & PEDIATRICS	238,122	238,122	0	0	0	20.00
21.00	43.00	NURSERY	145,023	145,023	0	0	0	21.00
200.00			7,631,027	6,475,020	1,156,007		7,500	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	421,576	21,079	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	9,762	488	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	20,337	1,017	0	0	0	4.00
5.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	5.00
6.00	41.00	SUBPROVIDER - IRF	46,266	2,313	0	0	0	6.00
7.00	50.00	OPERATING ROOM	93,703	4,685	0	0	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	17,255	863	0	0	0	8.00
9.00	60.00	LABORATORY	30,035	1,502	0	0	0	9.00
10.00	65.00	RESPIRATORY THERAPY	30,505	1,525	0	0	0	10.00
11.00	69.00	ELECTROCARDIOLOGY	15,761	788	0	0	0	11.00
12.00	91.00	EMERGENCY	35,894	1,795	0	0	0	12.00
13.00	74.00	RENAL DIALYSIS	9,762	488	0	0	0	13.00
14.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	14.00
15.00	59.00	CARDIAC CATHETERIZATION	15,874	794	0	0	0	15.00
16.00	73.00	DRUGS CHARGED TO PATIENTS	13,219	661	0	0	0	16.00
17.00	43.00	NURSERY	13,788	689	0	0	0	17.00
18.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	9,762	488	0	0	0	18.00
19.00	64.00	INTRAVENOUS THERAPY	712	36	0	0	0	19.00
20.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	20.00
21.00	43.00	NURSERY	0	0	0	0	0	21.00
200.00			784,211	39,211	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	421,576	150,899	1,119,465		1.00
2.00	13.00	NURSING ADMINISTRATION	0	9,762	2,238	2,238		2.00
3.00	50.00	OPERATING ROOM	0	0	0	1,200,000		3.00
4.00	30.00	ADULTS & PEDIATRICS	0	20,337	6,263	113,290		4.00
5.00	31.00	INTENSIVE CARE UNIT	0	0	0	177,000		5.00
6.00	41.00	SUBPROVIDER - IRF	0	46,266	67,560	67,560		6.00
7.00	50.00	OPERATING ROOM	0	93,703	97,547	2,082,886		7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	0	17,255	2,941	2,941		8.00
9.00	60.00	LABORATORY	0	30,035	5,965	9,510		9.00
10.00	65.00	RESPIRATORY THERAPY	0	30,505	0	0		10.00
11.00	69.00	ELECTROCARDIOLOGY	0	15,761	7,439	7,439		11.00
12.00	91.00	EMERGENCY	0	35,894	8,260	1,338,209		12.00
13.00	74.00	RENAL DIALYSIS	0	9,762	2,238	2,238		13.00
14.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	292,954		14.00
15.00	59.00	CARDIAC CATHETERIZATION	0	15,874	4,176	31,671		15.00
16.00	73.00	DRUGS CHARGED TO PATIENTS	0	13,219	3,031	3,031		16.00
17.00	43.00	NURSERY	0	13,788	11,493	11,493		17.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0007

Period:
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	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		
18.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	0	9,762	2,238	2,238		18.00
19.00	64.00	INTRAVENOUS THERAPY	0	712	13	13		19.00
20.00	30.00	ADULTS & PEDIATRICS	0	0	0	238,122		20.00
21.00	43.00	NURSERY	0	0	0	145,023		21.00
200.00			0	784,211	372,301	6,847,321		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0007

Period:
From 07/01/2018
To 06/30/2019Worksheet B
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	7,118,219	7,118,219			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	17,791,344		17,791,344		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,873,243	33,581	0	1,906,824	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	70,006,241	386,797	8,463,562	125,220	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	15,759,428	1,167,315	443,091	38,829	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	884,008	47,239	0	1,423	8.00
9.00	00900	HOUSEKEEPING	4,916,473	89,162	126,459	24,798	9.00
10.00	01000	DIETARY	3,406,089	93,225	15,520	21,793	10.00
11.00	01100	CAFETERIA	1,838,603	83,816	25,735	21,357	11.00
13.00	01300	NURSING ADMINISTRATION	4,768,106	45,652	382,673	59,838	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,769,206	63,982	14,422	0	14.00
15.00	01500	PHARMACY	4,396,492	27,983	10,165	60,571	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,913,006	78,893	3,145	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	60,216	0	0	1,082	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	349,896	0	0	5,862	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	377,188	1,780	0	5,366	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	40,903,104	1,795,312	135,514	596,922	30.00
31.00	03100	INTENSIVE CARE UNIT	6,283,957	203,023	73,480	80,747	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	5,541,853	161,092	12,849	82,127	34.00
41.00	04100	SUBPROVIDER - IRF	5,800,162	126,814	6,121	69,210	41.00
43.00	04300	NURSERY	2,616,552	114,439	41,146	40,279	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	18,899,157	738,307	1,620,679	193,557	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,831,919	109,256	52,915	28,467	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,823,227	330,875	1,766,244	70,071	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	775,250	71,204	560,432	8,600	55.00
56.00	05600	RADIOISOTOPE	2,724,174	33,085	513,718	40,195	56.00
57.00	05700	CT SCAN	1,406,196	16,068	652,512	18,178	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	881,984	17,936	1,032,096	10,813	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,293,575	67,652	936,178	48,310	59.00
60.00	06000	LABORATORY	13,676,489	95,554	212,700	0	60.00
64.00	06400	INTRAVENOUS THERAPY	755,047	30,704	0	10,927	64.00
65.00	06500	RESPIRATORY THERAPY	3,307,012	34,834	107,244	45,295	65.00
66.00	06600	PHYSICAL THERAPY	11,416,495	226,824	32,485	2,617	66.00
69.00	06900	ELECTROCARDIOLOGY	1,370,059	60,089	446,135	19,470	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	328,492	33,085	1,920	4,532	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	24,802,362	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,039,475	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,650,188	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,060,729	9,157	17,174	12,369	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	144,718	2,343	0	2,154	76.10
76.97	07697	CARDIAC REHABILITATION	522,451	40,188	7,192	8,450	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	9,464,166	244,389	68,000	132,278	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	333,546,551	6,681,655	17,781,506	1,891,707	118.00
NONREIMBURSABLE COST CENTERS							
192.01	19201	OTHER NRCC	3,413,386	436,564	9,838	15,117	192.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	336,959,937	7,118,219	17,791,344	1,906,824	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0007

Period:
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	78,981,820					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	5,329,784	0	22,738,447			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	285,543	0	194,221	1,412,434		8.00
9.00	00900	HOUSEKEEPING	1,578,819	0	366,585	0	7,102,296	9.00
10.00	01000	DIETARY	1,082,763	0	383,291	0	122,747	10.00
11.00	01100	CAFETERIA	602,980	0	344,605	0	110,358	11.00
13.00	01300	NURSING ADMINISTRATION	1,609,244	0	187,698	0	60,109	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	565,659	0	263,057	0	84,243	14.00
15.00	01500	PHARMACY	1,376,240	0	115,051	0	36,845	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	610,797	0	324,363	0	103,876	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	18,767	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	108,918	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	117,667	0	7,316	0	2,343	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,296,670	0	7,381,331	963,855	2,363,841	30.00
31.00	03100	INTENSIVE CARE UNIT	2,033,252	0	834,716	121,486	267,314	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,775,074	0	662,322	80,378	212,106	34.00
41.00	04100	SUBPROVIDER - IRF	1,837,648	0	521,389	200,512	166,973	41.00
43.00	04300	NURSERY	861,041	0	470,509	46,203	150,679	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,567,588	0	3,035,506	0	972,108	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	619,220	0	449,200	0	143,854	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,446,322	0	1,360,373	0	435,654	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	433,361	0	292,750	0	93,752	55.00
56.00	05600	RADIOISOTOPE	1,013,738	0	136,025	0	43,561	56.00
57.00	05700	CT SCAN	640,773	0	66,061	0	21,156	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	594,811	0	73,744	0	23,616	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,330,471	0	278,147	0	89,075	59.00
60.00	06000	LABORATORY	4,281,527	0	392,863	0	125,813	60.00
64.00	06400	INTRAVENOUS THERAPY	243,909	0	126,239	0	40,428	64.00
65.00	06500	RESPIRATORY THERAPY	1,069,830	0	143,220	0	45,865	65.00
66.00	06600	PHYSICAL THERAPY	3,575,430	0	932,574	0	298,653	66.00
69.00	06900	ELECTROCARDIOLOGY	580,398	0	247,052	0	79,117	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	112,675	0	136,025	0	43,561	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,593,417	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,522,912	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,485,258	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	336,598	0	37,649	0	12,057	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	45,683	0	9,633	0	3,085	76.10
76.97	07697	CARDIAC REHABILITATION	177,045	0	165,230	0	52,914	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	3,033,659	0	1,004,793	0	321,781	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	77,795,491	0	20,943,538	1,412,434	6,527,484	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	OTHER NRCC	1,186,329	0	1,794,909	0	574,812	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	78,981,820	0	22,738,447	1,412,434	7,102,296	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0007

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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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	5,125,428					10.00
11.00	01100	CAFETERIA	0	3,027,454				11.00
13.00	01300	NURSING ADMINISTRATION	0	102,350	7,215,670			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	2,760,569		14.00
15.00	01500	PHARMACY	0	98,695	0	6,529	6,128,571	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	12,419	0	38	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,926,596	1,178,761	3,753,190	14,397	127,684	30.00
31.00	03100	INTENSIVE CARE UNIT	242,698	126,969	446,055	1,298	26,411	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	154,973	140,725	500,413	1,371	29,254	34.00
41.00	04100	SUBPROVIDER - IRF	801,161	146,596	514,352	2,366	5,029	41.00
43.00	04300	NURSERY	0	55,853	182,495	1,024	3,190	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	319,638	629,518	48,548	186,105	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	45,820	126,160	597	3,564	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	144,481	253	3,522	11,635	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	12,673	185	110	222	55.00
56.00	05600	RADIOISOTOPE	0	69,440	70,170	409	33,764	56.00
57.00	05700	CT SCAN	0	35,532	0	41	47,919	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	20,727	0	136	10,447	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	70,049	172,857	862	37,543	59.00
60.00	06000	LABORATORY	0	0	0	353	1	60.00
64.00	06400	INTRAVENOUS THERAPY	0	16,006	56,430	156	11,257	64.00
65.00	06500	RESPIRATORY THERAPY	0	96,800	0	519	1,624	65.00
66.00	06600	PHYSICAL THERAPY	0	3,266	11,813	3,413	490	66.00
69.00	06900	ELECTROCARDIOLOGY	0	38,578	39,411	540	2,380	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	11,269	0	133	8	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,531,080	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,113,612	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	22,081	5,426,419	73.00
74.00	07400	RENAL DIALYSIS	0	19,543	67,130	192	27,483	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	5,076	393	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	16,379	20,759	213	7	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	239,809	624,086	7,029	136,135	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,125,428	3,027,454	7,215,670	2,760,569	6,128,571	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	OTHER NRCC	0	0	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,125,428	3,027,454	7,215,670	2,760,569	6,128,571	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED ED PRGM	
					SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV		
			16.00	17.00	21.00	22.00	23.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,034,080					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	80,065			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		464,676		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0			524,117	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	400,783	0	63,120	366,332	0	30.00
31.00	03100	INTENSIVE CARE UNIT	56,915	0	0	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	62,232	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	50,639	0	0	0	0	41.00
43.00	04300	NURSERY	20,441	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	329,793	0	16,945	98,344	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,437	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	156,203	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	3,369	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	77,366	0	0	0	0	56.00
57.00	05700	CT SCAN	188,198	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58,034	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	145,443	0	0	0	0	59.00
60.00	06000	LABORATORY	330,849	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	11,020	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	68,742	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	144,121	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	89,655	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,380	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	178,818	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	173,599	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	157,300	0	0	0	524,117	73.00
74.00	07400	RENAL DIALYSIS	11,265	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	2,037	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	6,634	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	286,807	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,034,080	0	80,065	464,676	524,117	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	OTHER NRCC	0	0	0	0	0	192.01
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)	3,034,080	0	80,065	464,676	524,117	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV					22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)					23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	77,267,412	-429,452	76,837,960		30.00
31.00	03100	INTENSIVE CARE UNIT	10,798,321	0	10,798,321		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	9,416,769	0	9,416,769		34.00
41.00	04100	SUBPROVIDER - IRF	10,248,972	0	10,248,972		41.00
43.00	04300	NURSERY	4,603,851	0	4,603,851		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	33,655,793	-115,289	33,540,504		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,426,409	0	3,426,409		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,548,860	0	12,548,860		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	2,251,908	0	2,251,908		55.00
56.00	05600	RADIOISOTOPE	4,755,645	0	4,755,645		56.00
57.00	05700	CT SCAN	3,092,634	0	3,092,634		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,724,344	0	2,724,344		58.00
59.00	05900	CARDIAC CATHETERIZATION	6,470,162	0	6,470,162		59.00
60.00	06000	LABORATORY	19,116,149	0	19,116,149		60.00
64.00	06400	INTRAVENOUS THERAPY	1,302,123	0	1,302,123		64.00
65.00	06500	RESPIRATORY THERAPY	4,920,985	0	4,920,985		65.00
66.00	06600	PHYSICAL THERAPY	16,648,181	0	16,648,181		66.00
69.00	06900	ELECTROCARDIOLOGY	2,972,884	0	2,972,884		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	680,080	0	680,080		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	34,105,677	0	34,105,677		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,849,598	0	24,849,598		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,265,363	0	25,265,363		73.00
74.00	07400	RENAL DIALYSIS	1,611,346	0	1,611,346		74.00
76.00	03950	OTHER ANCILLARY	0	0	0		76.00
76.10	03550	OUTPATIENT PSYCH	215,122	0	215,122		76.10
76.97	07697	CARDIAC REHABILITATION	1,017,462	0	1,017,462		76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	15,562,932	0	15,562,932		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	329,528,982	-544,741	328,984,241		118.00
NONREIMBURSABLE COST CENTERS							
192.01	19201	OTHER NRCC	7,430,955	0	7,430,955		192.01
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	336,959,937	-544,741	336,415,196		202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	33,581	0	33,581	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	386,797	8,463,562	8,850,359	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	1,167,315	443,091	1,610,406	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	47,239	0	47,239	8.00
9.00	00900	HOUSEKEEPING	0	89,162	126,459	215,621	9.00
10.00	01000	DIETARY	0	93,225	15,520	108,745	10.00
11.00	01100	CAFETERIA	0	83,816	25,735	109,551	11.00
13.00	01300	NURSING ADMINISTRATION	0	45,652	382,673	428,325	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	63,982	14,422	78,404	14.00
15.00	01500	PHARMACY	0	27,983	10,165	38,148	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	78,893	3,145	82,038	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	1,780	0	1,780	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	1,795,312	135,514	1,930,826	30.00
31.00	03100	INTENSIVE CARE UNIT	0	203,023	73,480	276,503	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	161,092	12,849	173,941	34.00
41.00	04100	SUBPROVIDER - IRF	0	126,814	6,121	132,935	41.00
43.00	04300	NURSERY	0	114,439	41,146	155,585	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	738,307	1,620,679	2,358,986	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	109,256	52,915	162,171	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	330,875	1,766,244	2,097,119	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	71,204	560,432	631,636	55.00
56.00	05600	RADIOISOTOPE	0	33,085	513,718	546,803	56.00
57.00	05700	CT SCAN	0	16,068	652,512	668,580	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	17,936	1,032,096	1,050,032	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	67,652	936,178	1,003,830	59.00
60.00	06000	LABORATORY	0	95,554	212,700	308,254	60.00
64.00	06400	INTRAVENOUS THERAPY	0	30,704	0	30,704	64.00
65.00	06500	RESPIRATORY THERAPY	0	34,834	107,244	142,078	65.00
66.00	06600	PHYSICAL THERAPY	0	226,824	32,485	259,309	66.00
69.00	06900	ELECTROCARDIOLOGY	0	60,089	446,135	506,224	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	33,085	1,920	35,005	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	9,157	17,174	26,331	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	2,343	0	2,343	76.10
76.97	07697	CARDIAC REHABILITATION	0	40,188	7,192	47,380	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	244,389	68,000	312,389	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	6,681,655	17,781,506	24,463,161	118.00
NONREIMBURSABLE COST CENTERS							
192.01	19201	OTHER NRCC	0	436,564	9,838	446,402	192.01
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	7,118,219	17,791,344	24,909,563	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,852,562					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	597,378	0	2,208,467			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	32,005	0	18,864	98,133		8.00
9.00	00900	HOUSEKEEPING	176,959	0	35,604	0	428,620	9.00
10.00	01000	DIETARY	121,359	0	37,227	0	7,408	10.00
11.00	01100	CAFETERIA	67,584	0	33,470	0	6,660	11.00
13.00	01300	NURSING ADMINISTRATION	180,369	0	18,230	0	3,628	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	63,401	0	25,549	0	5,084	14.00
15.00	01500	PHARMACY	154,253	0	11,174	0	2,224	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	68,460	0	31,504	0	6,269	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	2,103	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	12,208	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	13,188	0	711	0	141	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,490,373	0	716,911	66,966	142,655	30.00
31.00	03100	INTENSIVE CARE UNIT	227,893	0	81,072	8,441	16,132	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	198,956	0	64,328	5,585	12,800	34.00
41.00	04100	SUBPROVIDER - IRF	205,969	0	50,640	13,931	10,077	41.00
43.00	04300	NURSERY	96,508	0	45,698	3,210	9,093	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	736,115	0	294,823	0	58,666	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	69,404	0	43,628	0	8,682	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	274,191	0	132,126	0	26,291	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	48,572	0	28,433	0	5,658	55.00
56.00	05600	RADIOISOTOPE	113,623	0	13,211	0	2,629	56.00
57.00	05700	CT SCAN	71,820	0	6,416	0	1,277	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	66,668	0	7,162	0	1,425	58.00
59.00	05900	CARDIAC CATHETERIZATION	149,123	0	27,015	0	5,376	59.00
60.00	06000	LABORATORY	479,886	0	38,157	0	7,593	60.00
64.00	06400	INTRAVENOUS THERAPY	27,338	0	12,261	0	2,440	64.00
65.00	06500	RESPIRATORY THERAPY	119,910	0	13,910	0	2,768	65.00
66.00	06600	PHYSICAL THERAPY	400,745	0	90,576	0	18,024	66.00
69.00	06900	ELECTROCARDIOLOGY	65,053	0	23,995	0	4,775	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	12,629	0	13,211	0	2,629	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	851,093	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	619,025	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	502,721	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	37,727	0	3,657	0	728	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	5,120	0	936	0	186	76.10
76.97	07697	CARDIAC REHABILITATION	19,844	0	16,048	0	3,193	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	340,022	0	97,590	0	19,419	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,719,595	0	2,034,137	98,133	393,930	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	OTHER NRCC	132,967	0	174,330	0	34,690	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	8,852,562	0	2,208,467	98,133	428,620	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0007

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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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	275,122					10.00
11.00	01100	CAFETERIA	0	217,641				11.00
13.00	01300	NURSING ADMINISTRATION	0	7,358	638,963			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	172,438		14.00
15.00	01500	PHARMACY	0	7,095	0	408	214,367	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	893	0	2	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	210,771	84,738	332,353	899	4,466	30.00
31.00	03100	INTENSIVE CARE UNIT	13,027	9,128	39,499	81	924	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	8,319	10,117	44,313	86	1,023	34.00
41.00	04100	SUBPROVIDER - IRF	43,005	10,539	45,547	148	176	41.00
43.00	04300	NURSERY	0	4,015	16,160	64	112	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	22,979	55,745	3,032	6,510	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,294	11,172	37	125	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,387	22	220	407	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	911	16	7	8	55.00
56.00	05600	RADIOISOTOPE	0	4,992	6,214	26	1,181	56.00
57.00	05700	CT SCAN	0	2,554	0	3	1,676	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,490	0	8	365	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	5,036	15,307	54	1,313	59.00
60.00	06000	LABORATORY	0	0	0	22	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,151	4,997	10	394	64.00
65.00	06500	RESPIRATORY THERAPY	0	6,959	0	32	57	65.00
66.00	06600	PHYSICAL THERAPY	0	235	1,046	213	17	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,773	3,490	34	83	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	810	0	8	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	95,643	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	69,558	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,379	189,807	73.00
74.00	07400	RENAL DIALYSIS	0	1,405	5,945	12	961	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	365	35	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	1,177	1,838	13	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	17,240	55,264	439	4,762	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	275,122	217,641	638,963	172,438	214,367	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	OTHER NRCC	0	0	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	275,122	217,641	638,963	172,438	214,367	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0007

Period:
From 07/01/2018
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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED ED PRGM	
					SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS		
					APPRV	APPRV		
			16.00	17.00	21.00	22.00	23.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	188,271					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	2,122			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		12,311		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0			16,809	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	25,115	0				30.00
31.00	03100	INTENSIVE CARE UNIT	3,526	0				31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	3,856	0				34.00
41.00	04100	SUBPROVIDER - IRF	3,138	0				41.00
43.00	04300	NURSERY	1,267	0				43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	20,434	0				50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	956	0				52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,678	0				54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	209	0				55.00
56.00	05600	RADIOISOTOPE	4,794	0				56.00
57.00	05700	CT SCAN	11,660	0				57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,596	0				58.00
59.00	05900	CARDIAC CATHETERIZATION	9,011	0				59.00
60.00	06000	LABORATORY	20,499	0				60.00
64.00	06400	INTRAVENOUS THERAPY	683	0				64.00
65.00	06500	RESPIRATORY THERAPY	4,259	0				65.00
66.00	06600	PHYSICAL THERAPY	8,930	0				66.00
69.00	06900	ELECTROCARDIOLOGY	5,555	0				69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	519	0				70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,079	0				71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,756	0				72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,746	0				73.00
74.00	07400	RENAL DIALYSIS	698	0				74.00
76.00	03950	OTHER ANCILLARY	0	0				76.00
76.10	03550	OUTPATIENT PSYCH	126	0				76.10
76.97	07697	CARDIAC REHABILITATION	411	0				76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	17,770	0				91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	188,271	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	OTHER NRCC	0	0				192.01
200.00		Cross Foot Adjustments			2,122	12,311	16,809	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	188,271	0	2,122	12,311	16,809	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0007

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,016,612	0	5,016,612	30.00
31.00	03100	INTENSIVE CARE UNIT	677,646	0	677,646	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	524,769	0	524,769	34.00
41.00	04100	SUBPROVIDER - IRF	517,322	0	517,322	41.00
43.00	04300	NURSERY	332,420	0	332,420	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,560,695	0	3,560,695	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	299,970	0	299,970	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,551,674	0	2,551,674	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	715,601	0	715,601	55.00
56.00	05600	RADIOISOTOPE	694,180	0	694,180	56.00
57.00	05700	CT SCAN	764,306	0	764,306	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,130,936	0	1,130,936	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,216,915	0	1,216,915	59.00
60.00	06000	LABORATORY	854,411	0	854,411	60.00
64.00	06400	INTRAVENOUS THERAPY	80,170	0	80,170	64.00
65.00	06500	RESPIRATORY THERAPY	290,770	0	290,770	65.00
66.00	06600	PHYSICAL THERAPY	779,141	0	779,141	66.00
69.00	06900	ELECTROCARDIOLOGY	612,324	0	612,324	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	64,891	0	64,891	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	957,815	0	957,815	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	699,339	0	699,339	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	703,653	0	703,653	73.00
74.00	07400	RENAL DIALYSIS	77,682	0	77,682	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	9,149	0	9,149	76.10
76.97	07697	CARDIAC REHABILITATION	90,053	0	90,053	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	867,222	0	867,222	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,089,666	0	24,089,666	118.00
NONREIMBURSABLE COST CENTERS						
192.01	19201	OTHER NRCC	788,655	0	788,655	192.01
200.00		Cross Foot Adjustments	31,242	0	31,242	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	24,909,563	0	24,909,563	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0007

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

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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	960,011					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		12,252,300				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,529	0	106,138,297			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	52,166	5,828,572	6,970,202	-78,981,820	257,978,117	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	157,432	305,142	2,161,391	0	17,408,663	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,371	0	79,203	0	932,670	8.00
9.00	00900	HOUSEKEEPING	12,025	87,088	1,380,358	0	5,156,892	9.00
10.00	01000	DIETARY	12,573	10,688	1,213,083	0	3,536,627	10.00
11.00	01100	CAFETERIA	11,304	17,723	1,188,822	0	1,969,511	11.00
13.00	01300	NURSING ADMINISTRATION	6,157	263,534	3,330,832	0	5,256,269	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,629	9,932	0	0	1,847,610	14.00
15.00	01500	PHARMACY	3,774	7,000	3,371,600	0	4,495,211	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,640	2,166	0	0	1,995,044	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	60,216	0	61,298	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	326,312	0	355,758	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	240	0	298,667	0	384,334	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	242,128	93,324	33,224,147	0	43,430,852	30.00
31.00	03100	INTENSIVE CARE UNIT	27,381	50,603	4,494,662	0	6,641,207	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	21,726	8,849	4,571,509	0	5,797,921	34.00
41.00	04100	SUBPROVIDER - IRF	17,103	4,215	3,852,505	0	6,002,307	41.00
43.00	04300	NURSERY	15,434	28,336	2,242,067	0	2,812,416	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	99,573	1,116,107	10,774,138	0	21,451,700	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,735	36,441	1,584,557	0	2,022,557	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	44,624	1,216,353	3,900,442	0	7,990,417	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	9,603	385,951	478,709	0	1,415,486	55.00
56.00	05600	RADIOISOTOPE	4,462	353,780	2,237,418	0	3,311,172	56.00
57.00	05700	CT SCAN	2,167	449,363	1,011,862	0	2,092,954	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,419	710,770	601,905	0	1,942,829	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,124	644,714	2,689,103	0	4,345,715	59.00
60.00	06000	LABORATORY	12,887	146,479	0	0	13,984,743	60.00
64.00	06400	INTRAVENOUS THERAPY	4,141	0	608,240	0	796,678	64.00
65.00	06500	RESPIRATORY THERAPY	4,698	73,855	2,521,319	0	3,494,385	65.00
66.00	06600	PHYSICAL THERAPY	30,591	22,371	145,658	0	11,678,421	66.00
69.00	06900	ELECTROCARDIOLOGY	8,104	307,238	1,083,763	0	1,895,753	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,462	1,322	252,292	0	368,029	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	24,802,362	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	18,039,475	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	14,650,188	73.00
74.00	07400	RENAL DIALYSIS	1,235	11,827	688,526	0	1,099,429	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	316	0	119,877	0	149,215	76.10
76.97	07697	CARDIAC REHABILITATION	5,420	4,953	470,366	0	578,281	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	32,960	46,829	7,363,081	0	9,908,833	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	901,133	12,245,525	105,296,832	-78,981,820	254,103,212	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	OTHER NRCC	58,878	6,775	841,465	0	3,874,905	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	7,118,219	17,791,344	1,906,824		78,981,820	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.414726	1.452082	0.017965		0.306157	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			33,581		8,852,562	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000316		0.034315	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: 14-0007

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
7.00	00700	OPERATION OF PLANT	0	745,884			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,371	84,558		8.00
9.00	00900	HOUSEKEEPING	0	12,025	0	727,488	9.00
10.00	01000	DIETARY	0	12,573	0	12,573	191,989 10.00
11.00	01100	CAFETERIA	0	11,304	0	11,304	0 11.00
13.00	01300	NURSING ADMINISTRATION	0	6,157	0	6,157	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8,629	0	8,629	0 14.00
15.00	01500	PHARMACY	0	3,774	0	3,774	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,640	0	10,640	0 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0 17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0 22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	240	0	240	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	242,128	57,703	242,128	147,083 30.00
31.00	03100	INTENSIVE CARE UNIT	0	27,381	7,273	27,381	9,091 31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	21,726	4,812	21,726	5,805 34.00
41.00	04100	SUBPROVIDER - IRF	0	17,103	12,004	17,103	30,010 41.00
43.00	04300	NURSERY	0	15,434	2,766	15,434	0 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	99,573	0	99,573	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	14,735	0	14,735	0 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	44,624	0	44,624	0 54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	9,603	0	9,603	0 55.00
56.00	05600	RADIOISOTOPE	0	4,462	0	4,462	0 56.00
57.00	05700	CT SCAN	0	2,167	0	2,167	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,419	0	2,419	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	9,124	0	9,124	0 59.00
60.00	06000	LABORATORY	0	12,887	0	12,887	0 60.00
64.00	06400	INTRAVENOUS THERAPY	0	4,141	0	4,141	0 64.00
65.00	06500	RESPIRATORY THERAPY	0	4,698	0	4,698	0 65.00
66.00	06600	PHYSICAL THERAPY	0	30,591	0	30,591	0 66.00
69.00	06900	ELECTROCARDIOLOGY	0	8,104	0	8,104	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	4,462	0	4,462	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	0	1,235	0	1,235	0 74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0 76.00
76.10	03550	OUTPATIENT PSYCH	0	316	0	316	0 76.10
76.97	07697	CARDIAC REHABILITATION	0	5,420	0	5,420	0 76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	32,960	0	32,960	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	687,006	84,558	668,610	191,989 118.00
NONREIMBURSABLE COST CENTERS							
192.01	19201	OTHER NRCC	0	58,878	0	58,878	0 192.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	22,738,447	1,412,434	7,102,296	5,125,428 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	30.485232	16.703730	9.762767	26.696467 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	2,208,467	98,133	428,620	275,122 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	2.960872	1.160541	0.589178	1.433009 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: 14-0007

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

Worksheet B-1

Date/Time Prepared:
11/29/2019 8:41 am

Cost Center Description			CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	178,926					11.00
13.00	01300	NURSING ADMINISTRATION	6,049	1,595,438				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	44,532,782			14.00
15.00	01500	PHARMACY	5,833	0	105,321	15,480,219		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	2,020,841,614	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	734	0	618	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	69,666	829,858	232,250	322,519	266,479,226	30.00
31.00	03100	INTENSIVE CARE UNIT	7,504	98,626	20,931	66,712	37,918,145	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	8,317	110,645	22,123	73,893	41,460,268	34.00
41.00	04100	SUBPROVIDER - IRF	8,664	113,727	38,163	12,703	33,736,962	41.00
43.00	04300	NURSERY	3,301	40,351	16,511	8,057	13,618,564	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	18,891	139,191	783,162	470,084	219,715,412	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,708	27,895	9,629	9,003	10,284,609	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,539	56	56,811	29,388	104,066,289	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	749	41	1,776	560	2,244,436	55.00
56.00	05600	RADIOISOTOPE	4,104	15,515	6,600	85,284	51,543,091	56.00
57.00	05700	CT SCAN	2,100	0	656	121,039	125,381,485	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,225	0	2,191	26,389	38,663,610	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,140	38,220	13,899	94,830	96,897,187	59.00
60.00	06000	LABORATORY	0	0	5,696	2	220,419,194	60.00
64.00	06400	INTRAVENOUS THERAPY	946	12,477	2,518	28,433	7,342,057	64.00
65.00	06500	RESPIRATORY THERAPY	5,721	0	8,365	4,102	45,797,696	65.00
66.00	06600	PHYSICAL THERAPY	193	2,612	55,064	1,237	96,016,650	66.00
69.00	06900	ELECTROCARDIOLOGY	2,280	8,714	8,719	6,012	59,729,888	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	666	0	2,138	19	5,583,259	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	24,699,126	0	119,132,405	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	17,964,386	0	115,655,448	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	356,207	13,706,651	104,796,624	73.00
74.00	07400	RENAL DIALYSIS	1,155	14,843	3,094	69,420	7,504,740	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	300	87	0	0	1,357,261	76.10
76.97	07697	CARDIAC REHABILITATION	968	4,590	3,441	17	4,419,683	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	14,173	137,990	113,387	343,865	191,077,425	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	178,926	1,595,438	44,532,782	15,480,219	2,020,841,614	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	OTHER NRCC	0	0	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,027,454	7,215,670	2,760,569	6,128,571	3,034,080	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.920146	4.522689	0.061990	0.395897	0.001501	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	217,641	638,963	172,438	214,367	188,271	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.216374	0.400494	0.003872	0.013848	0.000093	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: 14-0007

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

Worksheet B-1

Date/Time Prepared:
11/29/2019 8:41 am

Cost Center Description		INTERNS & RESIDENTS			PARAMED ED PRGM (ASSIGNED TIME)		
		SOCIAL SERVICE (TIME SPENT)	SERVICES-SALAR	SERVICES-OTHER			
			Y & FRINGES APPRV (ASSIGNED TIME)	PRGM COSTS APPRV (ASSIGNED TIME)			
		17.00	21.00	22.00	23.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	0				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	4,725			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		4,725		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0			100	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	3,725	3,725	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,000	1,000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	55.00
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
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,725	4,725	100	118.00
NONREIMBURSABLE COST CENTERS							
192.01	19201	OTHER NRCC	0	0	0	0	192.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	80,065	464,676	524,117	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	16.944974	98.344127	5,241.170000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	2,122	12,311	16,809	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.449101	2.605503	168.090000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0007

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/29/2019 8:41 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	76,837,960		76,837,960	6,263	76,844,223	30.00
31.00	03100	INTENSIVE CARE UNIT	10,798,321		10,798,321	0	10,798,321	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	9,416,769		9,416,769	0	9,416,769	34.00
41.00	04100	SUBPROVIDER - IRF	10,248,972		10,248,972	67,560	10,316,532	41.00
43.00	04300	NURSERY	4,603,851		4,603,851	11,493	4,615,344	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	33,540,504		33,540,504	97,547	33,638,051	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,426,409		3,426,409	0	3,426,409	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,548,860		12,548,860	2,941	12,551,801	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	2,251,908		2,251,908	0	2,251,908	55.00
56.00	05600	RADIOISOTOPE	4,755,645		4,755,645	0	4,755,645	56.00
57.00	05700	CT SCAN	3,092,634		3,092,634	0	3,092,634	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,724,344		2,724,344	0	2,724,344	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,470,162		6,470,162	4,176	6,474,338	59.00
60.00	06000	LABORATORY	19,116,149		19,116,149	5,965	19,122,114	60.00
64.00	06400	INTRAVENOUS THERAPY	1,302,123		1,302,123	13	1,302,136	64.00
65.00	06500	RESPIRATORY THERAPY	4,920,985	0	4,920,985	0	4,920,985	65.00
66.00	06600	PHYSICAL THERAPY	16,648,181	0	16,648,181	0	16,648,181	66.00
69.00	06900	ELECTROCARDIOLOGY	2,972,884		2,972,884	7,439	2,980,323	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	680,080		680,080	0	680,080	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	34,105,677		34,105,677	0	34,105,677	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,849,598		24,849,598	0	24,849,598	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,265,363		25,265,363	3,031	25,268,394	73.00
74.00	07400	RENAL DIALYSIS	1,611,346		1,611,346	2,238	1,613,584	74.00
76.00	03950	OTHER ANCILLARY	0		0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	215,122		215,122	0	215,122	76.10
76.97	07697	CARDIAC REHABILITATION	1,017,462		1,017,462	0	1,017,462	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	15,562,932		15,562,932	8,260	15,571,192	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	14,134,531		14,134,531		14,134,531	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	343,118,772	0	343,118,772	216,926	343,335,698	200.00
201.00		Less Observation Beds	14,134,531		14,134,531		14,134,531	201.00
202.00		Total (see instructions)	328,984,241	0	328,984,241	216,926	329,201,167	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-0007		Period: From 07/01/2018 To 06/30/2019		Worksheet C Part I Date/Time Prepared: 11/29/2019 8:41 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	193,141,297		193,141,297				30.00	
31.00	03100	INTENSIVE CARE UNIT	37,918,145		37,918,145				31.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	41,460,268		41,460,268				34.00	
41.00	04100	SUBPROVIDER - IRF	33,736,962		33,736,962				41.00	
43.00	04300	NURSERY	13,618,564		13,618,564				43.00	
ANCILLARY SERVICE COST CENTERS										
50.00	05000	OPERATING ROOM	87,245,590	132,469,822	219,715,412	0.152654	0.000000	50.00		
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,656,336	2,628,273	10,284,609	0.333159	0.000000	52.00		
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,310,143	82,756,146	104,066,289	0.120585	0.000000	54.00		
55.00	05500	RADIOLOGY - THERAPEUTIC	666,515	1,577,921	2,244,436	1.003329	0.000000	55.00		
56.00	05600	RADIOISOTOPE	22,903,957	28,639,134	51,543,091	0.092265	0.000000	56.00		
57.00	05700	CT SCAN	45,983,158	79,398,327	125,381,485	0.024666	0.000000	57.00		
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	14,302,805	24,360,805	38,663,610	0.070463	0.000000	58.00		
59.00	05900	CARDIAC CATHETERIZATION	37,357,172	59,540,015	96,897,187	0.066773	0.000000	59.00		
60.00	06000	LABORATORY	109,277,205	111,141,989	220,419,194	0.086726	0.000000	60.00		
64.00	06400	INTRAVENOUS THERAPY	197,201	7,144,856	7,342,057	0.177351	0.000000	64.00		
65.00	06500	RESPIRATORY THERAPY	36,092,119	9,705,577	45,797,696	0.107450	0.000000	65.00		
66.00	06600	PHYSICAL THERAPY	38,355,927	57,660,723	96,016,650	0.173388	0.000000	66.00		
69.00	06900	ELECTROCARDIOLOGY	28,961,312	30,768,576	59,729,888	0.049772	0.000000	69.00		
70.00	07000	ELECTROENCEPHALOGRAPHY	1,486,400	4,096,859	5,583,259	0.121807	0.000000	70.00		
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	65,869,798	53,262,607	119,132,405	0.286284	0.000000	71.00		
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	69,449,277	46,206,171	115,655,448	0.214859	0.000000	72.00		
73.00	07300	DRUGS CHARGED TO PATIENTS	66,981,663	37,814,961	104,796,624	0.241089	0.000000	73.00		
74.00	07400	RENAL DIALYSIS	6,816,180	688,560	7,504,740	0.214710	0.000000	74.00		
76.00	03950	OTHER ANCILLARY	0	0	0	0.000000	0.000000	76.00		
76.10	03550	OUTPATIENT PSYCH	1,026,993	330,268	1,357,261	0.158497	0.000000	76.10		
76.97	07697	CARDIAC REHABILITATION	5,952	4,413,731	4,419,683	0.230212	0.000000	76.97		
OUTPATIENT SERVICE COST CENTERS										
91.00	09100	EMERGENCY	59,479,042	131,598,383	191,077,425	0.081448	0.000000	91.00		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	10,825,416	62,512,513	73,337,929	0.192732	0.000000	92.00		
SPECIAL PURPOSE COST CENTERS										
113.00	11300	INTEREST EXPENSE						113.00		
200.00		Subtotal (see instructions)	1,052,125,397	968,716,217	2,020,841,614			200.00		
201.00		Less Observation Beds						201.00		
202.00		Total (see instructions)	1,052,125,397	968,716,217	2,020,841,614			202.00		

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0007

Period:
From 07/01/2018
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT			34.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.153098		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.333159		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.120614		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	1.003329		55.00
56.00	05600	RADIOISOTOPE	0.092265		56.00
57.00	05700	CT SCAN	0.024666		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.070463		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.066817		59.00
60.00	06000	LABORATORY	0.086753		60.00
64.00	06400	INTRAVENOUS THERAPY	0.177353		64.00
65.00	06500	RESPIRATORY THERAPY	0.107450		65.00
66.00	06600	PHYSICAL THERAPY	0.173388		66.00
69.00	06900	ELECTROCARDIOLOGY	0.049897		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.121807		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.286284		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.214859		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.241118		73.00
74.00	07400	RENAL DIALYSIS	0.215009		74.00
76.00	03950	OTHER ANCILLARY	0.000000		76.00
76.10	03550	OUTPATIENT PSYCH	0.158497		76.10
76.97	07697	CARDIAC REHABILITATION	0.230212		76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.081492		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.192732		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0007

Period:
From 07/01/2018
To 06/30/2019Worksheet C
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				Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE		Total Costs	
						Disallowance			
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	76,837,960		76,837,960	6,263	76,844,223	30.00	
31.00	03100	INTENSIVE CARE UNIT	10,798,321		10,798,321	0	10,798,321	31.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	9,416,769		9,416,769	0	9,416,769	34.00	
41.00	04100	SUBPROVIDER - IRF	10,248,972		10,248,972	67,560	10,316,532	41.00	
43.00	04300	NURSERY	4,603,851		4,603,851	11,493	4,615,344	43.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	33,540,504		33,540,504	97,547	33,638,051	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,426,409		3,426,409	0	3,426,409	52.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,548,860		12,548,860	2,941	12,551,801	54.00	
55.00	05500	RADIOLOGY - THERAPEUTIC	2,251,908		2,251,908	0	2,251,908	55.00	
56.00	05600	RADIOISOTOPE	4,755,645		4,755,645	0	4,755,645	56.00	
57.00	05700	CT SCAN	3,092,634		3,092,634	0	3,092,634	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,724,344		2,724,344	0	2,724,344	58.00	
59.00	05900	CARDIAC CATHETERIZATION	6,470,162		6,470,162	4,176	6,474,338	59.00	
60.00	06000	LABORATORY	19,116,149		19,116,149	5,965	19,122,114	60.00	
64.00	06400	INTRAVENOUS THERAPY	1,302,123		1,302,123	13	1,302,136	64.00	
65.00	06500	RESPIRATORY THERAPY	4,920,985	0	4,920,985	0	4,920,985	65.00	
66.00	06600	PHYSICAL THERAPY	16,648,181	0	16,648,181	0	16,648,181	66.00	
69.00	06900	ELECTROCARDIOLOGY	2,972,884		2,972,884	7,439	2,980,323	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	680,080		680,080	0	680,080	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	34,105,677		34,105,677	0	34,105,677	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,849,598		24,849,598	0	24,849,598	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	25,265,363		25,265,363	3,031	25,268,394	73.00	
74.00	07400	RENAL DIALYSIS	1,611,346		1,611,346	2,238	1,613,584	74.00	
76.00	03950	OTHER ANCILLARY	0		0	0	0	76.00	
76.10	03550	OUTPATIENT PSYCH	215,122		215,122	0	215,122	76.10	
76.97	07697	CARDIAC REHABILITATION	1,017,462		1,017,462	0	1,017,462	76.97	
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	15,562,932		15,562,932	8,260	15,571,192	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	14,134,531		14,134,531		14,134,531	92.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	343,118,772	0	343,118,772	216,926	343,335,698	200.00	
201.00		Less Observation Beds	14,134,531		14,134,531		14,134,531	201.00	
202.00		Total (see instructions)	328,984,241	0	328,984,241	216,926	329,201,167	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0007

Period:
From 07/01/2018
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			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	193,141,297		193,141,297		30.00
31.00	03100	INTENSIVE CARE UNIT	37,918,145		37,918,145		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	41,460,268		41,460,268		34.00
41.00	04100	SUBPROVIDER - IRF	33,736,962		33,736,962		41.00
43.00	04300	NURSERY	13,618,564		13,618,564		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	87,245,590	132,469,822	219,715,412	0.152654	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,656,336	2,628,273	10,284,609	0.333159	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,310,143	82,756,146	104,066,289	0.120585	0.000000
55.00	05500	RADIOLOGY - THERAPEUTIC	666,515	1,577,921	2,244,436	1.003329	0.000000
56.00	05600	RADIOISOTOPE	22,903,957	28,639,134	51,543,091	0.092265	0.000000
57.00	05700	CT SCAN	45,983,158	79,398,327	125,381,485	0.024666	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	14,302,805	24,360,805	38,663,610	0.070463	0.000000
59.00	05900	CARDIAC CATHETERIZATION	37,357,172	59,540,015	96,897,187	0.066773	0.000000
60.00	06000	LABORATORY	109,277,205	111,141,989	220,419,194	0.086726	0.000000
64.00	06400	INTRAVENOUS THERAPY	197,201	7,144,856	7,342,057	0.177351	0.000000
65.00	06500	RESPIRATORY THERAPY	36,092,119	9,705,577	45,797,696	0.107450	0.000000
66.00	06600	PHYSICAL THERAPY	38,355,927	57,660,723	96,016,650	0.173388	0.000000
69.00	06900	ELECTROCARDIOLOGY	28,961,312	30,768,576	59,729,888	0.049772	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	1,486,400	4,096,859	5,583,259	0.121807	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	65,869,798	53,262,607	119,132,405	0.286284	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	69,449,277	46,206,171	115,655,448	0.214859	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	66,981,663	37,814,961	104,796,624	0.241089	0.000000
74.00	07400	RENAL DIALYSIS	6,816,180	688,560	7,504,740	0.214710	0.000000
76.00	03950	OTHER ANCILLARY	0	0	0	0.000000	0.000000
76.10	03550	OUTPATIENT PSYCH	1,026,993	330,268	1,357,261	0.158497	0.000000
76.97	07697	CARDIAC REHABILITATION	5,952	4,413,731	4,419,683	0.230212	0.000000
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	59,479,042	131,598,383	191,077,425	0.081448	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	10,825,416	62,512,513	73,337,929	0.192732	0.000000
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	1,052,125,397	968,716,217	2,020,841,614		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	1,052,125,397	968,716,217	2,020,841,614		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0007

Period:
From 07/01/2018
To 06/30/2019Worksheet C
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Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT			34.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03950	OTHER ANCILLARY	0.000000		76.00
76.10	03550	OUTPATIENT PSYCH	0.000000		76.10
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0007

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part I
Date/Time Prepared:
11/29/2019 8:41 am

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	5,016,612	0	5,016,612	70,709	70.95	30.00
31.00	INTENSIVE CARE UNIT	677,646		677,646	7,273	93.17	31.00
34.00	SURGICAL INTENSIVE CARE UNIT	524,769		524,769	4,812	109.05	34.00
41.00	SUBPROVIDER - IRF	517,322	0	517,322	12,004	43.10	41.00
43.00	NURSERY	332,420		332,420	2,766	120.18	43.00
200.00	Total (lines 30 through 199)	7,068,769		7,068,769	97,564		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	26,882	1,907,278				30.00
31.00	INTENSIVE CARE UNIT	2,090	194,725				31.00
34.00	SURGICAL INTENSIVE CARE UNIT	1,809	197,271				34.00
41.00	SUBPROVIDER - IRF	8,771	378,030				41.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	39,552	2,677,304				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0007

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part II
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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	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	3,560,695	219,715,412	0.016206	37,809,387	612,739	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	299,970	10,284,609	0.029167	17,352	506	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,551,674	104,066,289	0.024520	9,466,671	232,123	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	715,601	2,244,436	0.318833	207,062	66,018	55.00
56.00	05600 RADIOISOTOPE	694,180	51,543,091	0.013468	10,262,722	138,218	56.00
57.00	05700 CT SCAN	764,306	125,381,485	0.006096	24,587,376	149,885	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,130,936	38,663,610	0.029251	6,662,590	194,887	58.00
59.00	05900 CARDIAC CATHETERIZATION	1,216,915	96,897,187	0.012559	18,873,434	237,031	59.00
60.00	06000 LABORATORY	854,411	220,419,194	0.003876	50,021,952	193,885	60.00
64.00	06400 INTRAVENOUS THERAPY	80,170	7,342,057	0.010919	93,820	1,024	64.00
65.00	06500 RESPIRATORY THERAPY	290,770	45,797,696	0.006349	15,828,252	100,494	65.00
66.00	06600 PHYSICAL THERAPY	779,141	96,016,650	0.008115	8,960,084	72,711	66.00
69.00	06900 ELECTROCARDIOLOGY	612,324	59,729,888	0.010252	15,868,097	162,680	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	64,891	5,583,259	0.011622	658,874	7,657	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	957,815	119,132,405	0.008040	29,222,394	234,948	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	699,339	115,655,448	0.006047	30,481,903	184,324	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	703,653	104,796,624	0.006714	28,543,483	191,641	73.00
74.00	07400 RENAL DIALYSIS	77,682	7,504,740	0.010351	3,965,858	41,051	74.00
76.00	03950 OTHER ANCILLARY	0	0	0.000000	0	0	76.00
76.10	03550 OUTPATIENT PSYCH	9,149	1,357,261	0.006741	124,380	838	76.10
76.97	07697 CARDIAC REHABILITATION	90,053	4,419,683	0.020375	2,819	57	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	867,222	191,077,425	0.004539	27,334,583	124,072	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	922,745	73,337,929	0.012582	4,798,306	60,372	92.00
200.00	Total (lines 50 through 199)	17,943,642	1,700,966,378		323,791,399	3,007,161	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0007		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part III Date/Time Prepared: 11/29/2019 8:41 am		
					Title XVIII		Hospital		PPS		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost				
			1A	1.00	2A	2.00	3.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00		
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	0	34.00		
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	41.00		
43.00	04300	NURSERY	0	0	0	0	0	0	43.00		
200.00	Total (lines 30 through 199)		0	0	0	0	0	0	200.00		
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)		Inpatient Program Days			
			4.00	5.00	6.00	7.00		8.00			
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	70,709	0.00		26,882		30.00	
31.00	03100	INTENSIVE CARE UNIT		0	7,273	0.00		2,090		31.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	4,812	0.00		1,809		34.00	
41.00	04100	SUBPROVIDER - IRF	0	0	12,004	0.00		8,771		41.00	
43.00	04300	NURSERY		0	2,766	0.00		0		43.00	
200.00	Total (lines 30 through 199)			0	97,564			39,552		200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)								
			9.00								
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0								30.00
31.00	03100	INTENSIVE CARE UNIT	0								31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0								34.00
41.00	04100	SUBPROVIDER - IRF	0								41.00
43.00	04300	NURSERY	0								43.00
200.00	Total (lines 30 through 199)		0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0007

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

Worksheet D
Part IV
Date/Time Prepared:
11/29/2019 8:41 am

Cost Center Description			Title XVIII		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
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
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	524,117	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
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
200.00		Total (lines 50 through 199)	0	0	0	0	524,117	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0007

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part IV
Date/Time Prepared:
11/29/2019 8:41 am

Cost Center Description		Title XVIII		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)	
		4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	219,715,412	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	10,284,609	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	104,066,289	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	2,244,436	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	51,543,091	0.000000	56.00
57.00	05700	CT SCAN	0	0	125,381,485	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	38,663,610	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	96,897,187	0.000000	59.00
60.00	06000	LABORATORY	0	0	220,419,194	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	7,342,057	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	45,797,696	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	96,016,650	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	59,729,888	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	5,583,259	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	119,132,405	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	115,655,448	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	524,117	524,117	0.005001	73.00
74.00	07400	RENAL DIALYSIS	0	0	7,504,740	0.000000	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0.000000	76.00
76.10	03550	OUTPATIENT PSYCH	0	0	1,357,261	0.000000	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	4,419,683	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	191,077,425	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	73,337,929	0.000000	92.00
200.00		Total (lines 50 through 199)	0	524,117	524,117	1,700,966,378	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0007

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part IV
Date/Time Prepared:
11/29/2019 8:41 am

Cost Center Description		Title XVIII			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	37,809,387	0	33,176,661	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	17,352	0	258	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	9,466,671	0	14,497,767	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	207,062	0	1,065,514	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	10,262,722	0	8,755,678	0	56.00
57.00	05700	CT SCAN	0.000000	24,587,376	0	17,554,927	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	6,662,590	0	7,546,172	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	18,873,434	0	26,456,458	0	59.00
60.00	06000	LABORATORY	0.000000	50,021,952	0	17,128,693	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	93,820	0	2,868,701	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	15,828,252	0	1,343,459	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	8,960,084	0	3,645,315	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	15,868,097	0	7,425,506	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	658,874	0	1,019,079	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	29,222,394	0	16,466,682	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	30,481,903	0	16,943,140	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.005001	28,543,483	142,746	13,685,284	68,440	73.00
74.00	07400	RENAL DIALYSIS	0.000000	3,965,858	0	230,577	0	74.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0.000000	124,380	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0.000000	2,819	0	1,925,384	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.000000	27,334,583	0	21,238,279	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	4,798,306	0	18,411,342	0	92.00
200.00		Total (lines 50 through 199)		323,791,399	142,746	231,384,876	68,440	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0007

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part V
Date/Time Prepared:
11/29/2019 8:41 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	0.152654	33,176,661	0	0	5,064,550	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.333159	258	0	0	86	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.120585	14,497,767	0	0	1,748,213	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	1.003329	1,065,514	0	0	1,069,061	55.00
56.00	05600	RADIOISOTOPE	0.092265	8,755,678	0	0	807,843	56.00
57.00	05700	CT SCAN	0.024666	17,554,927	0	0	433,010	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.070463	7,546,172	0	0	531,726	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.066773	26,456,458	0	0	1,766,577	59.00
60.00	06000	LABORATORY	0.086726	17,128,693	0	0	1,485,503	60.00
64.00	06400	INTRAVENOUS THERAPY	0.177351	2,868,701	0	0	508,767	64.00
65.00	06500	RESPIRATORY THERAPY	0.107450	1,343,459	0	0	144,355	65.00
66.00	06600	PHYSICAL THERAPY	0.173388	3,645,315	0	0	632,054	66.00
69.00	06900	ELECTROCARDIOLOGY	0.049772	7,425,506	0	0	369,582	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.121807	1,019,079	0	0	124,131	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.286284	16,466,682	0	0	4,714,148	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.214859	16,943,140	0	0	3,640,386	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.241089	13,685,284	0	55,988	3,299,371	73.00
74.00	07400	RENAL DIALYSIS	0.214710	230,577	0	0	49,507	74.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0.158497	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0.230212	1,925,384	0	0	443,247	76.97
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.081448	21,238,279	0	0	1,729,815	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.192732	18,411,342	0	0	3,548,455	92.00
200.00		Subtotal (see instructions)		231,384,876	0	55,988	32,110,387	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0		201.00
		Only Charges						
202.00		Net Charges (line 200 - line 201)		231,384,876	0	55,988	32,110,387	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0007

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part V
Date/Time Prepared:
11/29/2019 8:41 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0		55.00
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
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,498		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OTHER ANCILLARY	0	0		76.00
76.10	03550	OUTPATIENT PSYCH	0	0		76.10
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	13,498		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	13,498		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0007	Period: From 07/01/2018 To 06/30/2019	Worksheet D Part II Date/Time Prepared: 11/29/2019 8:41 am		
				Component CCN: 14-T007				
				Title XVIII		Subprovider - IRF	PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,560,695	219,715,412	0.016206	74,199	1,202	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	299,970	10,284,609	0.029167	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,551,674	104,066,289	0.024520	342,529	8,399	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	715,601	2,244,436	0.318833	0	0	55.00
56.00	05600	RADIOISOTOPE	694,180	51,543,091	0.013468	44,393	598	56.00
57.00	05700	CT SCAN	764,306	125,381,485	0.006096	519,038	3,164	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,130,936	38,663,610	0.029251	156,456	4,576	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,216,915	96,897,187	0.012559	165,037	2,073	59.00
60.00	06000	LABORATORY	854,411	220,419,194	0.003876	3,405,355	13,199	60.00
64.00	06400	INTRAVENOUS THERAPY	80,170	7,342,057	0.010919	2,500	27	64.00
65.00	06500	RESPIRATORY THERAPY	290,770	45,797,696	0.006349	1,162,258	7,379	65.00
66.00	06600	PHYSICAL THERAPY	779,141	96,016,650	0.008115	15,857,166	128,681	66.00
69.00	06900	ELECTROCARDIOLOGY	612,324	59,729,888	0.010252	219,699	2,252	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	64,891	5,583,259	0.011622	18,310	213	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	957,815	119,132,405	0.008040	558,119	4,487	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	699,339	115,655,448	0.006047	14,147	86	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	703,653	104,796,624	0.006714	1,905,145	12,791	73.00
74.00	07400	RENAL DIALYSIS	77,682	7,504,740	0.010351	430,972	4,461	74.00
76.00	03950	OTHER ANCILLARY	0	0	0.000000	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	9,149	1,357,261	0.006741	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	90,053	4,419,683	0.020375	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	867,222	191,077,425	0.004539	11,163	51	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	73,337,929	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	17,020,897	1,700,966,378		24,886,486	193,639	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0007 Component CCN: 14-T007		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 11/29/2019 8:41 am	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC		0	0	0	0	0	55.00
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
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	524,117	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY		0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH		0	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
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
200.00		Total (lines 50 through 199)		0	0	0	0	524,117	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0007 Component CCN: 14-T007		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 11/29/2019 8:41 am	
			Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	219,715,412	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	10,284,609	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	104,066,289	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	2,244,436	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	51,543,091	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	125,381,485	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	38,663,610	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	96,897,187	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	220,419,194	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	7,342,057	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	45,797,696	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	96,016,650	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	59,729,888	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	5,583,259	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	119,132,405	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	115,655,448	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	524,117	524,117	104,796,624	0.005001	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	7,504,740	0.000000	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0.000000	76.00
76.10	03550	OUTPATIENT PSYCH	0	0	0	1,357,261	0.000000	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	4,419,683	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	191,077,425	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	73,337,929	0.000000	92.00
200.00		Total (lines 50 through 199)	0	524,117	524,117	1,700,966,378		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0007 Component CCN: 14-T007		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 11/29/2019 8:41 am	
				Title XVIII		Subprovider - IRF		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		74,199	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		342,529	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000		0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000		44,393	0	0	0	56.00
57.00	05700	CT SCAN	0.000000		519,038	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		156,456	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		165,037	0	0	0	59.00
60.00	06000	LABORATORY	0.000000		3,405,355	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		2,500	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		1,162,258	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000		15,857,166	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		219,699	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		18,310	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		558,119	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		14,147	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.005001		1,905,145	9,528	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000		430,972	0	0	0	74.00
76.00	03950	OTHER ANCILLARY	0.000000		0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0.000000		0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0.000000		0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	0.000000		11,163	0	1,112	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		0	0	305	0	92.00
200.00		Total (lines 50 through 199)			24,886,486	9,528	1,417	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0007

Period:

Worksheet D

Component CCN: 14-T007

From 07/01/2018
To 06/30/2019Part V
Date/Time Prepared:
11/29/2019 8:41 am

Title XVIII

Subprovider -
IRF

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	0.152654	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.333159	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.120585	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	1.003329	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.092265	0	0	0	56.00
57.00	05700	CT SCAN	0.024666	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.070463	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.066773	0	0	0	59.00
60.00	06000	LABORATORY	0.086726	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.177351	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.107450	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.173388	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.049772	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.121807	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.286284	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.214859	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.241089	0	0	7,811	73.00
74.00	07400	RENAL DIALYSIS	0.214710	0	0	0	74.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0.158497	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0.230212	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.081448	1,112	0	0	91
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.192732	305	0	0	59
200.00		Subtotal (see instructions)		1,417	0	7,811	150
201.00		Less PBP Clinic Lab. Services-Program			0	0	201.00
202.00		Only Charges					
202.00		Net Charges (line 200 - line 201)		1,417	0	7,811	150

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0007

Period:

Worksheet D

Component CCN: 14-T007

From 07/01/2018
To 06/30/2019Part V
Date/Time Prepared:
11/29/2019 8:41 am

Title XVIII

Subprovider -
IRF

PPS

Cost Center Description			Costs		
			Cost	Cost	
			Reimbursed	Reimbursed	
			Services Subject To Ded. & Coins. (see inst.)	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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	55.00
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
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,883	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	1,883	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	1,883	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0007	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/29/2019 8:41 am
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		70,709	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		70,709	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)		57,703	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)		26,882	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)		76,844,223	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)		76,844,223	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)		76,844,223	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)		1,086.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		29,214,551	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)		29,214,551	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0007

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

Worksheet D-1

Date/Time Prepared:
11/29/2019 8:41 am

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	10,798,321	7,273	1,484.71	2,090	3,103,044
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT	9,416,769	4,812	1,956.93	1,809	3,540,086
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					44,733,274
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					80,590,955
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					2,299,274
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					3,149,907
52.00	Total Program excludable cost (sum of lines 50 and 51)					5,449,181
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					75,141,774
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					13,006
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,086.77
89.00	Observation bed cost (line 87 x line 88) (see instructions)					14,134,531

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0007

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

Worksheet D-1

Date/Time Prepared:
11/29/2019 8:41 am

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	5,016,612	76,844,223	0.065283	14,134,531	922,745	90.00
91.00 Nursing School cost	0	76,844,223	0.000000	14,134,531	0	91.00
92.00 Allied health cost	0	76,844,223	0.000000	14,134,531	0	92.00
93.00 All other Medical Education	0	76,844,223	0.000000	14,134,531	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0007 Component CCN: 14-T007	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/29/2019 8:41 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		12,004	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		12,004	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)		12,004	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)		8,771	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)		10,316,532	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)		10,316,532	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)		10,316,532	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)		859.42	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		7,537,973	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		7,537,973	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0007 Component CCN: 14-T007	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/29/2019 8:41 am
			Title XVIII	Subprovider - IRF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0
44.00 CORONARY CARE UNIT					
45.00 BURN INTENSIVE CARE UNIT					
46.00 SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0
47.00 OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,990,770
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					11,528,743
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					378,030
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					203,167
52.00 Total Program excludable cost (sum of lines 50 and 51)					581,197
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					10,947,546
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					0
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0007 Component CCN: 14-T007		Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/29/2019 8:41 am	
		Title XVIII		Subprovider - IRF	PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	517,322	10,316,532	0.050145	0	0
91.00	Nursing School cost	0	10,316,532	0.000000	0	0
92.00	Allied health cost	0	10,316,532	0.000000	0	0
93.00	All other Medical Education	0	10,316,532	0.000000	0	0

Health Financial Systems		PRESENCE ST. JOSEPH MEDICAL CENTER		In Lieu of Form CMS-2552-10	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0007	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/29/2019 8:41 am
			Title XVIII	Hospital	PPS
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		84,109,914	30.00
31.00	03100	INTENSIVE CARE UNIT		17,572,485	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		16,610,029	34.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.153098	37,809,387	5,788,542 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.333159	17,352	5,781 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.120614	9,466,671	1,141,813 54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	1.003329	207,062	207,751 55.00
56.00	05600	RADIOISOTOPE	0.092265	10,262,722	946,890 56.00
57.00	05700	CT SCAN	0.024666	24,587,376	606,472 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.070463	6,662,590	469,466 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.066817	18,873,434	1,261,066 59.00
60.00	06000	LABORATORY	0.086753	50,021,952	4,339,554 60.00
64.00	06400	INTRAVENOUS THERAPY	0.177353	93,820	16,639 64.00
65.00	06500	RESPIRATORY THERAPY	0.107450	15,828,252	1,700,746 65.00
66.00	06600	PHYSICAL THERAPY	0.173388	8,960,084	1,553,571 66.00
69.00	06900	ELECTROCARDIOLOGY	0.049897	15,868,097	791,770 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.121807	658,874	80,255 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.286284	29,222,394	8,365,904 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.214859	30,481,903	6,549,311 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.241118	28,543,483	6,882,348 73.00
74.00	07400	RENAL DIALYSIS	0.215009	3,965,858	852,695 74.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0 76.00
76.10	03550	OUTPATIENT PSYCH	0.158497	124,380	19,714 76.10
76.97	07697	CARDIAC REHABILITATION	0.230212	2,819	649 76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.081492	27,334,583	2,227,550 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.192732	4,798,306	924,787 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		323,791,399	44,733,274 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net charges (line 200 minus line 201)		323,791,399	202.00

Health Financial Systems		PRESENCE ST. JOSEPH MEDICAL CENTER		In Lieu of Form CMS-2552-10	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0007	Period: From 07/01/2018	Worksheet D-3
			Component CCN: 14-T007	To 06/30/2019	Date/Time Prepared: 11/29/2019 8:41 am
			Title XVIII	Subprovider - IRF	PPS
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	34.00
41.00	04100	SUBPROVIDER - IRF		24,918,441	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.153098	74,199	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.333159	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.120614	342,529	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	1.003329	0	55.00
56.00	05600	RADIOISOTOPE	0.092265	44,393	56.00
57.00	05700	CT SCAN	0.024666	519,038	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.070463	156,456	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.066817	165,037	59.00
60.00	06000	LABORATORY	0.086753	3,405,355	60.00
64.00	06400	INTRAVENOUS THERAPY	0.177353	2,500	64.00
65.00	06500	RESPIRATORY THERAPY	0.107450	1,162,258	65.00
66.00	06600	PHYSICAL THERAPY	0.173388	15,857,166	66.00
69.00	06900	ELECTROCARDIOLOGY	0.049897	219,699	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.121807	18,310	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.286284	558,119	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.214859	14,147	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.241118	1,905,145	73.00
74.00	07400	RENAL DIALYSIS	0.215009	430,972	74.00
76.00	03950	OTHER ANCILLARY	0.000000	0	76.00
76.10	03550	OUTPATIENT PSYCH	0.158497	0	76.10
76.97	07697	CARDIAC REHABILITATION	0.230212	0	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.081492	11,163	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.192732	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		24,886,486	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)		24,886,486	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0007	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prepared: 11/29/2019 8:41 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)		15,856,422	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		47,447,390	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)		1,226,671	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		17,348,820	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		395.33	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)		9.00	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)		5.85	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).		-4.00	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)		5.85	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)		5.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		4.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		1.00	11.00
12.00	Current year allowable FTE (see instructions)		5.00	12.00
13.00	Total allowable FTE count for the prior year.		3.68	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.		3.92	14.00
15.00	Sum of lines 12 through 14 divided by 3.		4.20	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		4.20	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.010624	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.009424	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.009424	21.00
22.00	IME payment adjustment (see instructions)		325,255	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		89,138	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)		-1.00	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)		325,255	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		89,138	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.49	30.00
31.00	Percentage of Medicaid patient days (see instructions)		21.76	31.00
32.00	Sum of lines 30 and 31		25.25	32.00
33.00	Allowable disproportionate share percentage (see instructions)		10.05	33.00
34.00	Disproportionate share adjustment (see instructions)		1,590,509	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0007	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prepared: 11/29/2019 8:41 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)	3,240,618	4,415,206		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	816,814	3,302,331		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	4,119,145			36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0			43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0			46.00
47.00	Subtotal (see instructions)	70,565,392			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)		70,654,530		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		5,523,113		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).		206,008		52.00
53.00	Nursing and Allied Health Managed Care payment		179,351		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)		142,746		58.00
59.00	Total (sum of amounts on lines 49 through 58)		76,705,748		59.00
60.00	Primary payer payments		20,382		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		76,685,366		61.00
62.00	Deductibles billed to program beneficiaries		6,110,104		62.00
63.00	Coinsurance billed to program beneficiaries		164,320		63.00
64.00	Allowable bad debts (see instructions)		1,518,143		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		986,793		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,084,637		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		71,397,735		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0		70.50
70.87	Demonstration payment adjustment amount before sequestration		0		70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0		70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)				70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		-462,189		70.93
70.94	HRR adjustment amount (see instructions)		-1,286,824		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0007

Period:
From 07/01/2018
To 06/30/2019Worksheet E
Part A
Date/Time Prepared:
11/29/2019 8:41 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	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	0	70.97
70.98	Low Volume Payment-3		0	0	70.98
70.99	HAC adjustment amount (see instructions)		560,548	0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		69,088,174	0	71.00
71.01	Sequestration adjustment (see instructions)		1,381,763	0	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	0	71.02
72.00	Interim payments		65,881,223	0	72.00
73.00	Tentative settlement (for contractor use only)		0	0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		1,825,188	0	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		973,504	0	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	0	94.00
95.00	Time value of money for operating expenses (see instructions)		0	0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	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	0	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	0	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.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0007

Period:
From 07/01/2018
To 06/30/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/29/2019 8:41 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	15,856,422	0	15,856,422		15,856,422
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	47,447,390	0		47,447,390	47,447,390
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00	1,226,671	0	270,505	956,166	1,226,671
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	17,348,820	0	4,539,578	12,809,242	17,348,820
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.009424	0.009424	0.009424	0.009424	
6.00	IME payment adjustment (see instructions)	22.00	325,255	0	81,470	243,785	325,255
6.01	IME payment adjustment for managed care (see instructions)	22.01	89,138	0	0	89,138	89,138
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	325,255	0	81,470	243,785	325,255
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	89,138	0	0	89,138	89,138
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1005	0.1005	0.1005	0.1005	
11.00	Disproportionate share adjustment (see instructions)	34.00	1,590,509	0	398,393	1,192,116	1,590,509
11.01	Uncompensated care payments	36.00	4,119,145	0	2,857,138	806,418	3,663,556
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	70,565,392	0	19,463,928	51,101,464	70,565,392
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	70,654,530	0	19,463,928	51,190,602	70,654,530
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	5,523,113	0	1,386,846	4,136,267	5,523,113
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0
17.01	Net organ aquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0007

Period:
From 07/01/2018
To 06/30/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/29/2019 8:41 am

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	20,850,774	55,326,869	76,177,643	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	5,151,764	0	1,291,468	3,860,296	5,151,764	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	69,456	0	19,698	49,758	69,456	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0062	0.0062	0.0062	0.0062		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	31,941	0	8,007	23,934	31,941	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0524	0.0524	0.0524	0.0524		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	269,952	0	67,673	202,279	269,952	25.00
26.00	Total prospective capital payments (see instructions)	12.00	5,523,113	0	1,386,846	4,136,267	5,523,113	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		N					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0007

Period:
From 07/01/2018
To 06/30/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/29/2019 8:41 am

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	15,856,422	15,856,422		15,856,422	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	47,447,390		47,447,390	47,447,390	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	1,226,671	270,505	956,166	1,226,671	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	17,348,820	4,539,578	12,809,242	17,348,820	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.009424	0.009424	0.009424		5.00
6.00	IME payment adjustment (see instructions)	22.00	325,255	81,470	243,785	325,255	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	89,138	23,324	65,814	89,138	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	325,255	81,470	243,785	325,255	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	89,138	23,324	65,814	89,138	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1005	0.1005	0.1005		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	1,590,509	398,393	1,192,116	1,590,509	11.00
11.01	Uncompensated care payments	36.00	4,119,145	816,814	3,302,331	4,119,145	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	70,565,392	17,423,604	53,141,788	70,565,392	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	70,654,530	17,446,928	53,207,602	70,654,530	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	5,523,113	1,386,846	4,136,267	5,523,113	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			18,833,774	57,343,869	76,177,643	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0007

Period:
From 07/01/2018
To 06/30/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/29/2019 8:41 am

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	5,151,764	1,291,468	3,860,296	5,151,764	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	69,456	19,698	49,758	69,456	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0062	0.0062	0.0062		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	31,941	8,007	23,934	31,941	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0524	0.0524	0.0524		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	269,952	67,673	202,279	269,952	25.00
26.00	Total prospective capital payments (see instructions)	12.00	5,523,113	1,386,846	4,136,267	5,523,113	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-462,189	-69,925	-392,264	-462,189	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-1,286,824	-390,067	-896,757	-1,286,824	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	560,548	560,548	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0007	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 11/29/2019 8:41 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		13,498	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		32,041,947	2.00
3.00	OPPS payments		28,432,381	3.00
4.00	Outlier payment (see instructions)		378,863	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		68,440	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		13,498	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		55,988	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)		55,988	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		55,988	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		42,490	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)		13,498	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)		28,879,684	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)		4,979,100	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)		23,914,082	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		71,849	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)		23,985,931	30.00
31.00	Primary payer payments		4,466	31.00
32.00	Subtotal (line 30 minus line 31)		23,981,465	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)		883,313	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		574,153	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		622,934	36.00
37.00	Subtotal (see instructions)		24,555,618	37.00
38.00	MSP-LCC reconciliation amount from PS&R		150	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)		24,555,468	40.00
40.01	Sequestration adjustment (see instructions)		491,109	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		23,797,225	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		267,134	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0007 Component CCN: 14-T007	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 11/29/2019 8:41 am
		Title XVIII	Subprovider - IRF	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		1,883	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		150	2.00
3.00	OPPS payments		803	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		1,883	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		7,811	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		7,811	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		7,811	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		5,928	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		1,883	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)		803	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)		0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		2,686	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,686	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		2,686	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)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		2,686	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)		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)		2,686	40.00
40.01	Sequestration adjustment (see instructions)		54	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		2,802	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-170	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0007

Period:
From 07/01/2018
To 06/30/2019Worksheet E-1
Part I
Date/Time Prepared:
11/29/2019 8:41 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		65,152,278		23,361,840	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		964,228		547,732	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	02/14/2019	235,283	02/14/2019	112,347	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)		-235,283		-112,347	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)		65,881,223		23,797,225	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		1,825,188		267,134	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		67,706,411		24,064,359	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: 14-0007

Period:

Worksheet E-1

Component CCN: 14-T007

From 07/01/2018
To 06/30/2019Part I
Date/Time Prepared:
11/29/2019 8:41 am

Title XVIII

Subprovider -
IRF

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					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		14,502,679		2,802	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)		0		0	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	02/14/2019	38,983		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)		-38,983		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)		14,463,696		2,802	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		69,385		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		170	6.02
7.00	Total Medicare program liability (see instructions)		14,533,081		2,632	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: 14-0007

Period:
From 07/01/2018
To 06/30/2019Worksheet E-1
Part II
Date/Time Prepared:
11/29/2019 8:41 am

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	8.00
9.00	Sequestration adjustment amount (see instructions)	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	30.00
31.00	Other Adjustment (specify)	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0007 Component CCN: 14-T007	Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part III Date/Time Prepared: 11/29/2019 8:41 am
		Title XVIII	Subprovider - IRF	PPS
		1.00		
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)	14,573,941 1.00		
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0154 2.00		
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	335,201 3.00		
4.00	Outlier Payments	27,196 4.00		
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00 5.00		
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00 5.01		
6.00	New Teaching program adjustment. (see instructions)	0.00 6.00		
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00 7.00		
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00 8.00		
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00 9.00		
10.00	Average Daily Census (see instructions)	32.887671 10.00		
11.00	Teaching Adjustment Factor (see instructions)	0.000000 11.00		
12.00	Teaching Adjustment (see instructions)	0 12.00		
13.00	Total PPS Payment (see instructions)	14,936,338 13.00		
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0 14.00		
15.00	Organ acquisition (DO NOT USE THIS LINE)	0 15.00		
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0 16.00		
17.00	Subtotal (see instructions)	14,936,338 17.00		
18.00	Primary payer payments	0 18.00		
19.00	Subtotal (line 17 less line 18).	14,936,338 19.00		
20.00	Deductibles	101,292 20.00		
21.00	Subtotal (line 19 minus line 20)	14,835,046 21.00		
22.00	Coinsurance	20,980 22.00		
23.00	Subtotal (line 21 minus line 22)	14,814,066 23.00		
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	9,356 24.00		
25.00	Adjusted reimbursable bad debts (see instructions)	6,081 25.00		
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	6,700 26.00		
27.00	Subtotal (sum of lines 23 and 25)	14,820,147 27.00		
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0 28.00		
29.00	Other pass through costs (see instructions)	9,528 29.00		
30.00	Outlier payments reconciliation	0 30.00		
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0 31.00		
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0 31.50		
31.99	Demonstration payment adjustment amount before sequestration	0 31.99		
32.00	Total amount payable to the provider (see instructions)	14,829,675 32.00		
32.01	Sequestration adjustment (see instructions)	296,594 32.01		
32.02	Demonstration payment adjustment amount after sequestration	0 32.02		
33.00	Interim payments	14,463,696 33.00		
34.00	Tentative settlement (for contractor use only)	0 34.00		
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	69,385 35.00		
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	7,470 36.00		
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	27,196 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		

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0007	Period: From 07/01/2018 To 06/30/2019	Worksheet E-4 Date/Time Prepared: 11/29/2019 8:41 am	
Title XVIII			Hospital	PPS	
			1.00		
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			9.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			5.85	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			-5.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			5.85	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			4.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			4.00	6.00
7.00	Enter the lesser of line 5 or line 6			4.00	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	3.29	3.29	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	3.29	3.29	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		1.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	4.29		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	3.67		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.30	3.21		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.10	3.72		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.10	3.72		17.00
18.00	Per resident amount	125,100.76	125,100.76		18.00
19.00	Approved amount for resident costs	12,510	465,375	477,885	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			477,885	25.00
		Inpatient Part	Managed care		
		A			
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	39,553	9,541		26.00
27.00	Total Inpatient Days (see instructions)	82,118	82,118		27.00
28.00	Ratio of inpatient days to total inpatient days	0.481661	0.116186		28.00
29.00	Program direct GME amount	230,179	55,524		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		7,846		30.00
31.00	Net Program direct GME amount			277,857	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0007	Period: From 07/01/2018 To 06/30/2019	Worksheet E-4 Date/Time Prepared: 11/29/2019 8:41 am
		Title XVIII	Hospital	PPS
			1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)			
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		7,504,740	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		92,119,698	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		20,382	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		92,099,316	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		32,125,918	42.00
43.00	Primary payer payments (see instructions)		4,466	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		32,121,452	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		124,220,768	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.741416	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.258584	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		277,857	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		206,008	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		71,849	50.00

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

Provider CCN: 14-0007

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

Worksheet G

Date/Time Prepared:

11/29/2019 8:41 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	3,009,076	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	187,535,469	0	0	0	4.00
5.00 Other receivable	0	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-135,284,790	0	0	0	6.00
7.00 Inventory	8,030,541	0	0	0	7.00
8.00 Prepaid expenses	0	0	0	0	8.00
9.00 Other current assets	1,259,906	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)	64,550,202	0	0	0	11.00
FIXED ASSETS					
12.00 Land	7,950,000	0	0	0	12.00
13.00 Land improvements	1,188,596	0	0	0	13.00
14.00 Accumulated depreciation	-365,754	0	0	0	14.00
15.00 Buildings	93,820,032	0	0	0	15.00
16.00 Accumulated depreciation	-4,871,323	0	0	0	16.00
17.00 Leasehold improvements	2,716,393	0	0	0	17.00
18.00 Accumulated depreciation	-235,138	0	0	0	18.00
19.00 Fixed equipment	1,648,238	0	0	0	19.00
20.00 Accumulated depreciation	-1,115,930	0	0	0	20.00
21.00 Automobiles and trucks	21,638	0	0	0	21.00
22.00 Accumulated depreciation	-6,411	0	0	0	22.00
23.00 Major movable equipment	25,288,609	0	0	0	23.00
24.00 Accumulated depreciation	-8,429,744	0	0	0	24.00
25.00 Minor equipment depreciable	0	0	0	0	25.00
26.00 Accumulated depreciation	0	0	0	0	26.00
27.00 HIT designated Assets	0	0	0	0	27.00
28.00 Accumulated depreciation	0	0	0	0	28.00
29.00 Minor equipment-nondepreciable	0	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	117,609,206	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	111,764	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	111,764	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	182,271,172	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	2,502,742	0	0	0	37.00
38.00 Salaries, wages, and fees payable	0	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	0	0	0	0	40.00
41.00 Deferred income	1,243,541	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	45,257,652	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	49,003,935	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	776,018	0	0	0	46.00
47.00 Notes payable	0	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	0	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	776,018	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	49,779,953	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	132,491,219	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	132,491,219	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	182,271,172	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0007

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

Worksheet G-1

Date/Time Prepared:
11/29/2019 8:41 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		151,574,985		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,758,795				2.00
3.00	Total (sum of line 1 and line 2)		153,333,780		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		153,333,780		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	NET ASSET TRANSFERS	20,842,561		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		20,842,561		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		132,491,219		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00	NET ASSET TRANSFERS		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: 14-0007

Period:
From 07/01/2018
To 06/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
11/29/2019 8:41 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	206,759,861		206,759,861	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	33,736,962		33,736,962	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)	240,496,823		240,496,823	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	37,918,145		37,918,145	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT	41,460,268		41,460,268	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	79,378,413		79,378,413	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	319,875,236		319,875,236	17.00
18.00	Ancillary services	732,250,161	774,605,320	1,506,855,481	18.00
19.00	Outpatient services	0	194,110,896	194,110,896	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NON REIMBURSABLE	18,019	2,523,191	2,541,210	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	1,052,143,416	971,239,407	2,023,382,823	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		352,327,335		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	ROUNDING	4			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)		4		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		352,327,339		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0007

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

Worksheet G-3

Date/Time Prepared:
11/29/2019 8:41 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	2,023,382,823	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,674,574,053	2.00
3.00	Net patient revenues (line 1 minus line 2)	348,808,770	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	352,327,339	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,518,569	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	130,845	6.00
7.00	Income from investments	300,650	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	1,320,975	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	ALL OTHERS	3,524,894	24.00
24.01	OTHER GAINS	0	24.01
25.00	Total other income (sum of lines 6-24)	5,277,364	25.00
26.00	Total (line 5 plus line 25)	1,758,795	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,758,795	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0007	Period: From 07/01/2018 To 06/30/2019	Worksheet L Parts I-III Date/Time Prepared: 11/29/2019 8:41 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		5,151,764	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		69,456	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)		192.09	3.00
4.00	Number of interns & residents (see instructions)		4.20	4.00
5.00	Indirect medical education percentage (see instructions)		0.62	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)		31,941	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		3.49	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		21.76	8.00
9.00	Sum of lines 7 and 8		25.25	9.00
10.00	Allowable disproportionate share percentage (see instructions)		5.24	10.00
11.00	Disproportionate share adjustment (see instructions)		269,952	11.00
12.00	Total prospective capital payments (see instructions)		5,523,113	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