

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: 14-0052	Period: From 10/01/2018 To 09/30/2019	Worksheet S Parts I-III Date/Time Prepared: 2/20/2020 8:51 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 OSF SAINT ANTHONY'S HEALTH CENTER (14-0052) for the cost reporting period beginning 10/01/2018 and ending 09/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) _____
 Officer or Administrator of Provider(s)

 Title

 Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	29,212	-52,521	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	29,212	-52,521	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: 14-0052		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/20/2020 8:51 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: SAINT ANTHONY'S WAY			PO Box: 340				1.00	
2.00	City: ALTON			State: IL		Zip Code: 62002-0340		County: MADISON	
		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			OSF SAINT ANTHONY'S HEALTH CENTER	140052	41180	1	07/01/1966	N
4.00	Subprovider - IPF							P	
5.00	Subprovider - IRF							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)						10/01/2018	09/30/2019	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.			265	120	0	0	1,679	0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0052

Period:
From 10/01/2018
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Part I
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	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
					Urban/Rural S	Date of Geogr	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	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	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	47.00
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	48.00
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N		56.00
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							57.00
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		58.00
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		59.00
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1.00	2.00	3.00	
60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)				N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0052

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part I
Date/Time Prepared:
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	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00		2.00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
64.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		64.00

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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	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0
	Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	
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

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				1.00	
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			Y	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	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.		N	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.		N	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.		N	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.		N	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.		N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
			Physical	Occupational	
			1.00	2.00	
			Speech	Respiratory	
			3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N	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

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			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.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	27,578	0	66,080	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	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		149006	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0052		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/20/2020 8:51 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: OSF HEALTHCARE SYSTEM		Contractor's Name: NGS		Contractor's Number: 06101				141.00	
142.00	Street: 800 NE GLEN OAK AVENUE		PO Box:						142.00	
143.00	City: PEORIA		State: IL		Zip Code: 61603				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		08/28/2019		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								146.00	
								1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								Y	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			166.00
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								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)						10/01/2018	09/30/2019	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	171.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0052	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part II Date/Time Prepared: 2/20/2020 8:51 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	01/29/2020 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 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	Y		15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	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	12/13/2019	Y 12/13/2019
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: 14-0052	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part II Date/Time Prepared: 2/20/2020 8:51 am
		Description	Y/N	Y/N
		0	1.00	3.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		Y	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		Y	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N	33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N	40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LOUIS	RAPTOPOULOS	41.00
42.00	Enter the employer/company name of the cost report preparer.	OSF SAINT ANTHONY'S HEALTH CENTER		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	309-624-9230	LOUIS.C.RAPTOPOULOS@OSFHEALTHCARE.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0052

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part II
Date/Time Prepared:
2/20/2020 8:51 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.	GOVT REPORTING SR ANALYST	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: 14-0052

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/20/2020 8:51 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	38	13,870	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)		38	13,870	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	11	4,015	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		49	17,885	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		49			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0052

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/20/2020 8:51 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,783	236	8,215			1.00
2.00	HMO and other (see instructions)	1,883	1,799				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,783	236	8,215			7.00
8.00	INTENSIVE CARE UNIT	420	29	1,115			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	0			13.00
14.00	Total (see instructions)	4,203	265	9,330	0.00	441.95	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	441.95	27.00
28.00	Observation Bed Days		371	1,349			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0052

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/20/2020 8:51 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,122	65	2,435	1.00
2.00 HMO and other (see instructions)			444	360		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,122	65	2,435	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0052

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part II
Date/Time Prepared:
2/20/2020 8:51 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	25,186,843	-32,840	25,154,003	879,969.00	28.59
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		4,363	0	4,363	30.00	145.43
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		57,451	20,906	78,357	3,560.00	22.01
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		753,022	0	753,022	9,750.00	77.23
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		157,952	0	157,952	3,403.00	46.42
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		5,277,922	0	5,277,922	144,414.00	36.55
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		7,666,523	0	7,666,523		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		23,960	0	23,960		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		1,332	0	1,332		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		1,698,241	0	1,698,241		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	0	0	0	0.00	0.00
27.00	Administrative & General	5.00	2,781,775	63,612	2,845,387	76,881.00	37.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0052

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part II
Date/Time Prepared:
2/20/2020 8:51 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.)		458,476	0	458,476	3,713.00	123.48	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,047,595	7,286	1,054,881	50,836.00	20.75	30.00
31.00	Laundry & Linen Service	8.00	5,461	0	5,461	434.00	12.58	31.00
32.00	Housekeeping	9.00	838,424	0	838,424	57,691.00	14.53	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	405,225	651	405,876	22,478.00	18.06	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	441,673	-22,552	419,121	25,428.00	16.48	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	855,839	5,192	861,031	21,754.00	39.58	38.00
39.00	Central Services and Supply	14.00	37,345	29,462	66,807	3,250.00	20.56	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	529,280	0	529,280	22,329.00	23.70	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: 14-0052

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part III
Date/Time Prepared:
2/20/2020 8:51 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)	25,645,319	-32,840	25,612,479	883,682.00	28.98	1.00
2.00	Excluded area salaries (see instructions)	57,451	20,906	78,357	3,560.00	22.01	2.00
3.00	Subtotal salaries (line 1 minus line 2)	25,587,868	-53,746	25,534,122	880,122.00	29.01	3.00
4.00	Subtotal other wages & related costs (see inst.)	6,188,896	0	6,188,896	157,567.00	39.28	4.00
5.00	Subtotal wage-related costs (see inst.)	9,366,096	0	9,366,096	0.00	36.68	5.00
6.00	Total (sum of lines 3 thru 5)	41,142,860	-53,746	41,089,114	1,037,689.00	39.60	6.00
7.00	Total overhead cost (see instructions)	7,401,093	83,651	7,484,744	284,794.00	26.28	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0052	Period: From 10/01/2018 To 09/30/2019	Worksheet S-3 Part IV Date/Time Prepared: 2/20/2020 8:51 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		865,276	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)		615,948	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)		4,452,671	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		32,840	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		234,371	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		1,398,426	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		490	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		91,793	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		7,691,815	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0052

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part V
Date/Time Prepared:
2/20/2020 8:51 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	753,022	7,691,815	1.00
2.00	Hospital	753,022	7,691,815	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0052	Period: From 10/01/2018 To 09/30/2019	Worksheet S-10 Date/Time Prepared: 2/20/2020 8:51 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)			0.172242 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	11,742,911		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	110,637,363		6.00
7.00	Medicaid cost (line 1 times line 6)	19,056,401		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)	7,313,490		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)	7,313,490		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)	5,828,571	751,656	6,580,227 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,003,925	751,656	1,755,581 21.00
22.00	Payments received from patients for amounts previously written off as charity care	9,842	0	9,842 22.00
23.00	Cost of charity care (line 21 minus line 22)	994,083	751,656	1,745,739 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)	7,193,640		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	494,201		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	760,308		27.01
28.00	Non-Medicare bad debt expense (see instructions)	6,433,332		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,374,197		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,119,936		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	10,433,426		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0052

Period:
From 10/01/2018
To 09/30/2019

Worksheet A

Date/Time Prepared:
2/20/2020 8:51 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,944,277	1,944,277	91,677	2,035,954	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,208,919	1,208,919	41,586	1,250,505	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	7,714,013	7,714,013	1,085,094	8,799,107	4.00
5.01	00540	NONPATIENT TELEPHONES	585,721	59,457	645,178	64,701	709,879	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	330,705	110,750	441,455	0	441,455	5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	1,448	1,448	0	1,448	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	1,865,349	20,160,354	22,025,703	-2,280,519	19,745,184	5.05
7.00	00700	OPERATION OF PLANT	1,047,595	3,232,760	4,280,355	-537,407	3,742,948	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,461	228,975	234,436	0	234,436	8.00
9.00	00900	HOUSEKEEPING	838,424	246,840	1,085,264	0	1,085,264	9.00
10.00	01000	DIETARY	405,225	108,627	513,852	5,835	519,687	10.00
11.00	01100	CAFETERIA	441,673	459,369	901,042	-21,881	879,161	11.00
13.00	01300	NURSING ADMINISTRATION	855,839	156,265	1,012,104	6,090	1,018,194	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	37,345	600	37,945	127,205	165,150	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	529,280	162,006	691,286	0	691,286	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	584,164	584,164	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,963,616	1,559,299	4,522,915	4,367	4,527,282	30.00
31.00	03100	INTENSIVE CARE UNIT	1,152,230	852,128	2,004,358	-30,598	1,973,760	31.00
43.00	04300	NURSERY	0	18,665	18,665	0	18,665	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,099,084	3,425,140	6,524,224	-3,081,830	3,442,394	50.00
51.00	05100	RECOVERY ROOM	323,595	40,105	363,700	12,178	375,878	51.00
53.00	05300	ANESTHESIOLOGY	0	970,949	970,949	0	970,949	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,994,992	622,039	2,617,031	458,378	3,075,409	54.00
57.00	05700	CT SCAN	206,367	291,900	498,267	7,809	506,076	57.00
58.00	05800	MRI	118,570	30,843	149,413	18,925	168,338	58.00
59.00	05900	CARDIAC CATHETERIZATION	316,103	875,171	1,191,274	-721,998	469,276	59.00
60.00	06000	LABORATORY	1,675,108	1,955,461	3,630,569	105,712	3,736,281	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	186,146	186,146	0	186,146	62.00
64.00	06400	INTRAVENOUS THERAPY	494,697	113,170	607,867	45,276	653,143	64.00
65.00	06500	RESPIRATORY THERAPY	613,369	148,132	761,501	37,597	799,098	65.00
66.00	06600	PHYSICAL THERAPY	858,665	26,246	884,911	3,300	888,211	66.00
67.00	06700	OCCUPATIONAL THERAPY	360,083	5,980	366,063	36,426	402,489	67.00
68.00	06800	SPEECH PATHOLOGY	199,580	826	200,406	42,191	242,597	68.00
69.00	06900	ELECTROCARDIOLOGY	310,625	80,557	391,182	-60,136	331,046	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	81,133	230,870	312,003	14,490	326,493	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	-107,088	-107,088	2,115,693	2,008,605	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,529,264	1,529,264	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	897,369	7,858,078	8,755,447	142,481	8,897,928	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	485,066	11,368	496,434	0	496,434	76.03
76.04	03952	PAIN CLINIC	84,357	23,237	107,594	29,681	137,275	76.04
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	1,952,166	654,541	2,606,707	82,105	2,688,812	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		-4,167	-4,167	4,167	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,129,392	55,664,256	80,793,648	-37,977	80,755,671	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	743	743	0	743	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	355,509	355,509	37,977	393,486	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FUND DEVELOPMENT	0	104,936	104,936	0	104,936	193.02
193.05	19305	EMS	53,113	17,830	70,943	0	70,943	193.05
193.07	19307	SAINT CLARE'S VILLA	4,338	1,348	5,686	0	5,686	193.07
194.00	07950	UNUSED SPACE	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	25,186,843	56,144,622	81,331,465	0	81,331,465	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0052

Period:
From 10/01/2018
To 09/30/2019

Worksheet A

Date/Time Prepared:
2/20/2020 8:51 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	756,812	2,792,766	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	986,074	2,236,579	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-568	8,798,539	4.00
5.01	00540	NONPATIENT TELEPHONES	0	709,879	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	441,455	5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	1,448	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	-7,134,202	12,610,982	5.05
7.00	00700	OPERATION OF PLANT	0	3,742,948	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	234,436	8.00
9.00	00900	HOUSEKEEPING	0	1,085,264	9.00
10.00	01000	DIETARY	-6,520	513,167	10.00
11.00	01100	CAFETERIA	-362,169	516,992	11.00
13.00	01300	NURSING ADMINISTRATION	328,568	1,346,762	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	165,150	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-579	690,707	16.00
17.00	01700	SOCIAL SERVICE	-122,792	461,372	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,098,640	3,428,642	30.00
31.00	03100	INTENSIVE CARE UNIT	-244,372	1,729,388	31.00
43.00	04300	NURSERY	-16,844	1,821	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-3,918	3,438,476	50.00
51.00	05100	RECOVERY ROOM	0	375,878	51.00
53.00	05300	ANESTHESIOLOGY	-906,000	64,949	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,075,409	54.00
57.00	05700	CT SCAN	0	506,076	57.00
58.00	05800	MRI	0	168,338	58.00
59.00	05900	CARDIAC CATHETERIZATION	-100,000	369,276	59.00
60.00	06000	LABORATORY	-71,007	3,665,274	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	186,146	62.00
64.00	06400	INTRAVENOUS THERAPY	0	653,143	64.00
65.00	06500	RESPIRATORY THERAPY	0	799,098	65.00
66.00	06600	PHYSICAL THERAPY	-495	887,716	66.00
67.00	06700	OCCUPATIONAL THERAPY	-2,660	399,829	67.00
68.00	06800	SPEECH PATHOLOGY	0	242,597	68.00
69.00	06900	ELECTROCARDIOLOGY	-67,858	263,188	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-16,180	310,313	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,008,605	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,529,264	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-150,842	8,747,086	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	-6,891	489,543	76.03
76.04	03952	PAIN CLINIC	0	137,275	76.04
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-180,814	2,507,998	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)	-8,421,897	72,333,774	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	743	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	393,486	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
193.02	19302	FUND DEVELOPMENT	0	104,936	193.02
193.05	19305	EMS	0	70,943	193.05
193.07	19307	SAINT CLARE'S VILLA	0	5,686	193.07
194.00	07950	UNUSED SPACE	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-8,421,897	72,909,568	200.00

RECLASSIFICATIONS

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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS SHORT TERM DISABILITY					
1.00	NONPATIENT TELEPHONES	5.01	0	1,089		1.00
2.00	OPERATION OF PLANT	7.00	0	4,384		2.00
3.00	DIETARY	10.00	0	5,184		3.00
4.00	CAFETERIA	11.00	0	671		4.00
5.00	NURSING ADMINISTRATION	13.00	0	828		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	4,252		6.00
7.00	INTENSIVE CARE UNIT	31.00	0	547		7.00
8.00	OPERATING ROOM	50.00	0	11,667		8.00
9.00	LABORATORY	60.00	0	409		9.00
10.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.03	0	1,295		10.00
11.00	EMERGENCY	91.00	0	1,803		11.00
12.00	SAINT CLARE'S VILLA	193.07	0	711		12.00
	0		0	32,840		
	B - TO RECLASS PROPERTY INSURANCE					
1.00		0.00	0	0		1.00
2.00	OTHER CAP REL COSTS	3.00	0	133,263		2.00
	0		0	133,263		
	C - TO RECLASS REHAB ADMINISTRATION					
1.00		0.00	0	0		1.00
2.00	OCCUPATIONAL THERAPY	67.00	15,237	528		2.00
3.00	SPEECH PATHOLOGY	68.00	29,846	1,034		3.00
	0		45,083	1,562		
	D - TO RECLASS INTEREST EXPENSE					
1.00		0.00	0	0		1.00
2.00	INTEREST EXPENSE	113.00	0	4,167		2.00
	0		0	4,167		
	E - MINISTRY COST ALLOCATION					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,085,094		1.00
2.00	OPERATION OF PLANT	7.00	0	186,105		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	97,543		3.00
4.00	SOCIAL SERVICE	17.00	0	584,164		4.00
5.00	DRUGS CHARGED TO PATIENTS	73.00	0	108,266		5.00
6.00	PHYSICAL THERAPY	66.00	0	49,945		6.00
7.00	OCCUPATIONAL THERAPY	67.00	0	20,661		7.00
8.00	SPEECH PATHOLOGY	68.00	0	11,311		8.00
	0		0	2,143,089		
	F - RECLASS CANCER NAVIGATOR					
1.00	INTRAVENOUS THERAPY	64.00	44,275	1,001		1.00
	0		44,275	1,001		
	G - RECLASS MEDICAL BILLABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,115,693		1.00
2.00		0.00	0	0		2.00
	0		0	2,115,693		
	H - TO RECLASS IMPLANTABLE DEVICES					
1.00	INTENSIVE CARE UNIT	31.00	0	18		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,529,282		2.00
3.00		0.00	0	0		3.00
	0		0	1,529,300		
	J - RECLASS OF IMAGING MGR AND SPRVSR					
1.00	ELECTROENCEPHALOGRAPHY	70.00	10,054	0		1.00
2.00	PAIN CLINIC	76.04	10,054	0		2.00
3.00	CT SCAN	57.00	20,108	0		3.00
4.00	MRI	58.00	10,054	0		4.00
5.00	NONPATIENT TELEPHONES	5.01	60,325	0		5.00
	0		110,595	0		
	K - TO RECLASS STERILE PROCESSING					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	6,485	4,908		1.00
2.00	CT SCAN	57.00	6,485	4,908		2.00
3.00	RESPIRATORY THERAPY	65.00	6,485	4,908		3.00
4.00	PAIN CLINIC	76.04	8,647	6,544		4.00
5.00	EMERGENCY	91.00	25,939	19,631		5.00
6.00	PHYSICIANS' PRIVATE OFFICES	192.00	21,617	16,360		6.00
	TOTALS		75,658	57,259		
	M - RECLASS OF CARDIOLOGY MGR					
1.00	CARDIAC CATHETERIZATION	59.00	59,231	905		1.00
	0		59,231	905		
	N - RECLASS OF ICU MGR					
1.00	RESPIRATORY THERAPY	65.00	25,706	498		1.00
2.00	ADULTS & PEDIATRICS	30.00	4,284	83		2.00
	0		29,990	581		

RECLASSIFICATIONS

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Increases					
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
0 - TO RECLASS BIOMED EXPENSE					
1.00 RADIOLOGY-DIAGNOSTIC	54.00	0	629,470		1.00
2.00 LABORATORY	60.00	0	105,712		2.00
3.00	0.00	0	0		3.00
TOTALS		0	735,182		
P - TO RECLASS DRUGS CHARGED TO PATIENTS					
1.00 DRUGS CHARGED TO PATIENTS	73.00	0	34,215		1.00
2.00	0.00	0	0		2.00
3.00	0.00	0	0		3.00
4.00	0.00	0	0		4.00
0		0	34,215		
Q - TO RECLASS PEROPERATIVE SALARIES					
1.00 RECOVERY ROOM	51.00	12,039	139		1.00
2.00 CENTRAL SERVICES & SUPPLY	14.00	29,462	200		2.00
3.00 EMERGENCY	91.00	36,118	417		3.00
4.00 NURSING ADMINISTRATION	13.00	6,020	70		4.00
0		83,639	826		
R - TO RECLASS RADIOLOGY MANAGER SALARIE					
1.00 PAIN CLINIC	76.04	4,436	0		1.00
2.00 CT SCAN	57.00	8,871	0		2.00
3.00 MRI	58.00	8,871	0		3.00
4.00 ELECTROENCEPHALOGRAPHY	70.00	4,436	0		4.00
0		26,614	0		
S - TO RECLASS EVS AND FOOD DIRECTOR SAL					
1.00 NONPATIENT TELEPHONES	5.01	4,376	0		1.00
2.00 OPERATION OF PLANT	7.00	11,670	0		2.00
3.00 DIETARY	10.00	5,835	0		3.00
TOTALS		21,881	0		
500.00 Grand Total: Increases		496,966	6,789,883		500.00

RECLASSIFICATIONS

Provider CCN: 14-0052

Period:
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To 09/30/2019

Worksheet A-6

Date/Time Prepared:
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	Decreases						2/20/2020 8:31 am
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS SHORT TERM DISABILITY						
1.00	NONPATIENT TELEPHONES	5.01	1,089	0	0		1.00
2.00	OPERATION OF PLANT	7.00	4,384	0	0		2.00
3.00	DIETARY	10.00	5,184	0	0		3.00
4.00	CAFETERIA	11.00	671	0	0		4.00
5.00	NURSING ADMINISTRATION	13.00	828	0	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	4,252	0	0		6.00
7.00	INTENSIVE CARE UNIT	31.00	547	0	0		7.00
8.00	OPERATING ROOM	50.00	11,667	0	0		8.00
9.00	LABORATORY	60.00	409	0	0		9.00
10.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.03	1,295	0	0		10.00
11.00	EMERGENCY	91.00	1,803	0	0		11.00
12.00	SAINT CLARE'S VILLA	193.07	711	0	0		12.00
	0		32,840	0			
	B - TO RECLASS PROPERTY INSURANCE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	133,263	0		1.00
2.00		0.00	0	0	12		2.00
	0		0	133,263			
	C - TO RECLASS REHAB ADMINISTRATION						
1.00	PHYSICAL THERAPY	66.00	45,083	1,562	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		45,083	1,562			
	D - TO RECLASS INTEREST EXPENSE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	4,167	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	4,167			
	E - MINISTRY COST ALLOCATION						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	2,143,089	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
	0		0	2,143,089			
	F - RECLASS CANCER NAVIGATOR						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	44,275	1,001	0		1.00
	0		44,275	1,001			
	G - RECLASS MEDICAL BILLABLE SUPPLIES						
1.00	OPERATING ROOM	50.00	0	1,799,214	0		1.00
2.00	CARDIAC CATHETERIZATION	59.00	0	316,479	0		2.00
	0		0	2,115,693			
	H - TO RECLASS IMPLANTABLE DEVICES						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	18	0		1.00
2.00	OPERATING ROOM	50.00	0	1,063,627	0		2.00
3.00	CARDIAC CATHETERIZATION	59.00	0	465,655	0		3.00
	0		0	1,529,300			
	J - RECLASS OF IMAGING MGR AND SPRVSR						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	110,595	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	0		110,595	0			
	K - TO RECLASS STERILE PROCESSING						
1.00	OPERATING ROOM	50.00	75,658	57,259	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	TOTALS		75,658	57,259			
	M - RECLASS OF RADIOLOGY MGR						
1.00	ELECTROCARDIOLOGY	69.00	59,231	905	0		1.00
	0		59,231	905			

RECLASSIFICATIONS

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Period:
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To 09/30/2019Worksheet A-6
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	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	N - RECLASS OF ICU MGR						
1.00	INTENSIVE CARE UNIT	31.00	29,990	581	0		1.00
2.00		0.00	0	0	0		2.00
	0		29,990	581			
	O - TO RECLASS BIOMED EXPENSE						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00	OPERATION OF PLANT	7.00	0	735,182	0		3.00
	TOTALS		0	735,182			
	P - TO RECLASS DRUGS CHARGED TO PATIENTS						
1.00		0.00	0	0	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	45	0		2.00
3.00	OPERATING ROOM	50.00	0	1,607	0		3.00
4.00	CT SCAN	57.00	0	32,563	0		4.00
	0		0	34,215			
	Q - TO RECLASS PEROPERATIVE SALARIES						
1.00	OPERATING ROOM	50.00	83,639	826	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	0		83,639	826			
	R - TO RECLASS RADIOLOGY MANAGER SALARIE						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	26,614	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	0		26,614	0			
	S - TO RECLASS EVS AND FOOD DIRECTOR SAL						
1.00	CAFETERIA	11.00	21,881	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		21,881	0			
500.00	Grand Total: Decreases		529,806	6,757,043			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0052

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part I
Date/Time Prepared:
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		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,470,000	0	0	0	390,000	1.00
2.00	Land Improvements	6,930,417	68,034	0	68,034	156,328	2.00
3.00	Buildings and Fixtures	60,981,191	2,070,697	0	2,070,697	6,512,185	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	32,609,178	1,768,088	0	1,768,088	5,011,431	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	101,990,786	3,906,819	0	3,906,819	12,069,944	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	101,990,786	3,906,819	0	3,906,819	12,069,944	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,080,000	0				1.00
2.00	Land Improvements	6,842,123	0				2.00
3.00	Buildings and Fixtures	56,539,703	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	29,365,835	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	93,827,661	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	93,827,661	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0052

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part II
Date/Time Prepared:
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Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,944,277	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,208,919	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,153,196	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,944,277				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,208,919				2.00
3.00	Total (sum of lines 1-2)	0	3,153,196				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0052

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part III
Date/Time Prepared:
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Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	72,462,099	0	72,462,099	0.687943	91,677	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	32,869,397	0	32,869,397	0.312057	41,586	2.00
3.00	Total (sum of lines 1-2)	105,331,496	0	105,331,496	1.000000	133,263	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	91,677	2,342,917	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	41,586	2,010,718	0	2.00
3.00	Total (sum of lines 1-2)	0	0	133,263	4,353,635	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	358,172	91,677	0	0	2,792,766	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	184,275	41,586	0	0	2,236,579	2.00
3.00	Total (sum of lines 1-2)	542,447	133,263	0	0	5,029,345	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0052

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8

Date/Time Prepared:
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Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-1,030	0OTHER ADMINISTRATIVE AND GENERAL	5.05	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	B	-25,074	0OTHER ADMINISTRATIVE AND GENERAL	5.05	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	-2,810,642			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	-1,031,724			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	A	-361,863	0CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-579	0MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	B	-138,843	0OTHER ADMINISTRATIVE AND GENERAL	5.05	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	0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	0PHYSICAL 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	168,717	0CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	414,344	0CAP 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	0OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	0SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	NON PATIENT FOOD SALES	B	-306	0CAFETERIA	11.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0052

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8

Date/Time Prepared:
2/20/2020 8:51 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	
33.01	OTHER OPERATING REVENUES - ADMIN AND	B	-10,821	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.01
33.02	MANAGEMENT FEE - VILLA	B	-110,801	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.02
33.03	ADVERTISING - MEDICAL SURGICAL INTEN	A	-1,418	OPERATING ROOM	50.00	0	33.03
33.04	OTHER OPERATING REVENUES - DIETARY	B	-6,520	DIETARY	10.00	0	33.04
33.05	OTHER OPERATING REVENUES - NURSERY	B	-278	NURSERY	43.00	0	33.05
33.06	OTHER OPERATING REVENUES - MED PSYCH	B	-6,891	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.03	0	33.06
33.07	OTHER OPERATING REVENUES - PT	B	-495	PHYSICAL THERAPY	66.00	0	33.07
33.08	OTHER OPERATING REVENUES - OT	B	-2,660	OCCUPATIONAL THERAPY	67.00	0	33.08
33.09	OTHER OPERATING REVENUES - LAB	B	-350	LABORATORY	60.00	0	33.09
33.10	340B OFFSET	B	-150,842	DRUGS CHARGED TO PATIENTS	73.00	0	33.10
33.11	MEDICAID PROVIDER TAX	A	-4,320,551	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.11
33.12	UNEMPLOYMENT COMP	A	490	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.12
33.13	ADVERTISING - CARDIOLOGY SVCS	A	453	ELECTROCARDIOLOGY	69.00	0	33.13
33.14	ADVERTISING - ADMIN	A	-1,509	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.14
33.15	ADVERTISING - MEDICAL - SURGICAL ACU	A	-126	ADULTS & PEDIATRICS	30.00	0	33.15
33.16	ADVERTISING - SURGERY	A	-32	INTENSIVE CARE UNIT	31.00	0	33.16
33.17	ADVERTISING - EMERGENCY SERVICES	A	-13	EMERGENCY	91.00	0	33.17
33.18	RECRUITING EXPENSE - ICU	A	-500	INTENSIVE CARE UNIT	31.00	0	33.18
33.19	RECRUITING EXPENSE - SURGERY	A	-2,500	OPERATING ROOM	50.00	0	33.19
33.21	RECRUITING EXPENSE - ADMIN	A	-95	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.21
33.22	PHYSICIAN EMPLOYEE PART B EB	A	-568	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.22
33.25	LOBBYING DUES	A	-18,870	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.25
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,421,897				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: 14-0052

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8-1

Date/Time Prepared:
2/20/2020 8:51 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	1.00	CAP REL COSTS-BLDG & FIXT	MINISTRY CHARGES - BLDG	229,923	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	MINISTRY CHARGES - EQUIPMENT	1,109,299	721,844	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	MINISTRY CHARGES - POOLED EB	1,085,094	1,085,094	3.00
3.01	5.05	OTHER ADMINISTRATIVE AND GEN	MINISTRY CHARGES - POOLED A&	3,291,912	7,038,486	3.01
3.02	7.00	OPERATION OF PLANT	MINISTRY CHARGES - POOLED EN	626,022	626,022	3.02
3.03	31.00	INTENSIVE CARE UNIT	MINISTRY CHARGES - POOLED EI	147,310	147,310	3.03
3.04	54.00	RADIOLOGY-DIAGNOSTIC	MINISTRY CHARGES - POOLED IM	629,470	629,470	3.04
3.05	60.00	LABORATORY	MINISTRY CHARGES - POOLED LA	105,712	105,712	3.05
3.06	66.00	PHYSICAL THERAPY	MINISTRY CHARGES - POOLED RE	49,945	49,945	3.06
3.07	67.00	OCCUPATIONAL THERAPY	MINISTRY CHARGES - POOLED RE	20,661	20,661	3.07
3.08	68.00	SPEECH PATHOLOGY	MINISTRY CHARGES - POOLED RE	11,311	11,311	3.08
3.09	73.00	DRUGS CHARGED TO PATIENTS	MINISTRY CHARGES - POOLED PH	529,066	529,066	3.09
3.10	1.00	CAP REL COSTS-BLDG & FIXT	MINISTRY CHARGES - INTEREST	358,172	0	3.10
3.11	2.00	CAP REL COSTS-MVBLE EQUIP	MINISTRY CHARGES - INTEREST	184,275	0	3.11
4.00	5.05	OTHER ADMINISTRATIVE AND GEN	MINISTRY CHARGES - FUNCTIONA	3,584,192	2,343,341	4.00
4.01	13.00	NURSING ADMINISTRATION	MINISTRY CHARGES - FUNCTIONA	442,230	0	4.01
4.02	17.00	SOCIAL SERVICE	MINISTRY CHARGES - FUNCTIONA	461,372	584,164	4.02
4.03	30.00	ADULTS & PEDIATRICS	SFI RENT	5,698	10,962	4.03
4.04	57.00	CT SCAN	SFI CREDENTIALING	62,745	62,745	4.04
4.05	60.00	LABORATORY	SYSTEMS LAB	723,825	723,825	4.05
4.06	0.00			0	0	4.06
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			13,658,234	14,689,958	5.00

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

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

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

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

6.00	B	OSF HEALTHCARE	100.00	OSF HEALTHCARE	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-0052

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8-1

Date/Time Prepared:
2/20/2020 8:51 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	229,923	9		1.00
2.00	387,455	9		2.00
3.00	0	0		3.00
3.01	-3,746,574	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
3.06	0	0		3.06
3.07	0	0		3.07
3.08	0	0		3.08
3.09	0	0		3.09
3.10	358,172	11		3.10
3.11	184,275	11		3.11
4.00	1,240,851	0		4.00
4.01	442,230	0		4.01
4.02	-122,792	0		4.02
4.03	-5,264	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
5.00	-1,031,724			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	CATHOLIC SYSTEM		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: 14-0052

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8-2

Date/Time Prepared:
2/20/2020 8:51 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.05	OTHER ADMINISTRATIVE AND GENERAL	4,832	0	4,832	211,500	34	1.00
2.00	13.00	NURSING ADMINISTRATION	113,662	113,662	0	211,500	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	1,093,250	1,093,250	0	0	0	3.00
4.00	31.00	INTENSIVE CARE UNIT	243,840	243,840	0	0	0	4.00
5.00	43.00	NURSERY	16,566	16,566	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	906,000	906,000	0	0	0	6.00
7.00	59.00	CARDIAC CATHETERIZATION	100,000	100,000	0	0	0	7.00
8.00	60.00	LABORATORY	105,697	63,697	42,000	260,300	280	8.00
9.00	69.00	ELECTROCARDIOLOGY	68,311	68,311	0	0	0	9.00
10.00	70.00	ELECTROENCEPHALOGRAPHY	16,180	16,180	0	0	0	10.00
11.00	91.00	EMERGENCY	296,284	180,801	115,483	211,500	3,120	11.00
200.00			2,964,622	2,802,307	162,315		3,434	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	5.05	OTHER ADMINISTRATIVE AND GENERAL	3,457	173	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	4.00
5.00	43.00	NURSERY	0	0	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	6.00
7.00	59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	7.00
8.00	60.00	LABORATORY	35,040	1,752	0	0	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	9.00
10.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	10.00
11.00	91.00	EMERGENCY	317,250	15,863	0	0	0	11.00
200.00			355,747	17,788	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	5.05	OTHER ADMINISTRATIVE AND GENERAL	0	3,457	1,375	1,375		1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	113,662		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,093,250		3.00
4.00	31.00	INTENSIVE CARE UNIT	0	0	0	243,840		4.00
5.00	43.00	NURSERY	0	0	0	16,566		5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	906,000		6.00
7.00	59.00	CARDIAC CATHETERIZATION	0	0	0	100,000		7.00
8.00	60.00	LABORATORY	0	35,040	6,960	70,657		8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	68,311		9.00
10.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	16,180		10.00
11.00	91.00	EMERGENCY	0	317,250	0	180,801		11.00
200.00			0	355,747	8,335	2,810,642		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0052

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/20/2020 8:51 am

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,792,766	2,792,766			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,236,579	2,236,579			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,798,539	8,035	36	8,806,610	4.00
5.01	00540	NONPATIENT TELEPHONES	709,879	4,451	12,572	227,369	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	441,455	32,205	218	115,799	5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,448	15,096	0	0	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	12,610,982	574,007	530,660	653,167	5.05
7.00	00700	OPERATION OF PLANT	3,742,948	221,926	60,965	369,375	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	234,436	9,044	0	1,912	8.00
9.00	00900	HOUSEKEEPING	1,085,264	64,356	4,172	293,581	9.00
10.00	01000	DIETARY	513,167	59,326	6,226	142,121	10.00
11.00	01100	CAFETERIA	516,992	38,728	23,870	146,759	11.00
13.00	01300	NURSING ADMINISTRATION	1,346,762	8,324	79,910	301,497	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	165,150	64,646	22,330	23,393	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	690,707	18,862	0	185,332	16.00
17.00	01700	SOCIAL SERVICE	461,372	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,428,642	272,421	94,325	1,037,750	30.00
31.00	03100	INTENSIVE CARE UNIT	1,729,388	89,725	131,802	392,770	31.00
43.00	04300	NURSERY	1,821	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,438,476	144,895	620,127	1,030,298	50.00
51.00	05100	RECOVERY ROOM	375,878	5,856	18,739	117,525	51.00
53.00	05300	ANESTHESIOLOGY	64,949	596	23,015	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,075,409	59,769	222,698	637,285	54.00
57.00	05700	CT SCAN	506,076	5,526	8,706	84,679	57.00
58.00	05800	MRI	168,338	4,752	669	48,145	58.00
59.00	05900	CARDIAC CATHETERIZATION	369,276	13,136	17,264	131,426	59.00
60.00	06000	LABORATORY	3,665,274	85,102	85,961	586,409	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	186,146	2,745	1,771	0	62.00
64.00	06400	INTRAVENOUS THERAPY	653,143	32,524	6,069	188,725	64.00
65.00	06500	RESPIRATORY THERAPY	799,098	12,864	15,640	226,048	65.00
66.00	06600	PHYSICAL THERAPY	887,716	57,378	11,712	284,882	66.00
67.00	06700	OCCUPATIONAL THERAPY	399,829	44,402	10,418	131,421	67.00
68.00	06800	SPEECH PATHOLOGY	242,597	6,423	23,977	80,335	68.00
69.00	06900	ELECTROCARDIOLOGY	263,188	17,882	57,737	88,028	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	310,313	22,316	3,445	33,483	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,008,605	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,529,264	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,747,086	21,165	42,402	314,221	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	489,543	13,130	1,234	169,396	76.03
76.04	03952	PAIN CLINIC	137,275	2,993	1,421	37,640	76.04
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	2,507,998	77,958	48,212	699,672	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)	72,333,774	2,112,564	2,188,303	8,780,443	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	743	5,384	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	393,486	282,599	47,045	7,569	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.02	19302	FUND DEVELOPMENT	104,936	0	0	0	193.02
193.05	19305	EMS	70,943	921	1,231	18,598	193.05
193.07	19307	SAINT CLARE'S VILLA	5,686	0	0	0	193.07
194.00	07950	UNUSED SPACE	0	391,298	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	72,909,568	2,792,766	2,236,579	8,806,610	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0052

Period:
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Cost Center Description			NONPATIENT TELEPHONES	Subtotal	PURCHASING RECEIVING AND STORES	Subtotal	CASHIERING/ACC OUNTS RECEIVABLE	
			5.01	5A.01	5.02	5A.02	5.04	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	954,271					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	7,820	597,497	597,497			5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	219	16,763	139	16,902	16,902	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	190,562	14,559,378	120,286	14,679,664	3,396	5.05
7.00	00700	OPERATION OF PLANT	58,289	4,453,503	36,799	4,490,302	1,042	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,254	248,646	2,055	250,701	58	8.00
9.00	00900	HOUSEKEEPING	19,195	1,466,568	12,118	1,478,686	343	9.00
10.00	01000	DIETARY	9,560	730,400	6,035	736,435	171	10.00
11.00	01100	CAFETERIA	9,633	735,982	6,081	742,063	172	11.00
13.00	01300	NURSING ADMINISTRATION	23,029	1,759,522	14,539	1,774,061	412	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,654	279,173	2,307	281,480	65	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,868	906,769	7,493	914,262	212	16.00
17.00	01700	SOCIAL SERVICE	6,119	467,491	3,863	471,354	109	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	64,097	4,897,235	40,466	4,937,701	1,146	30.00
31.00	03100	INTENSIVE CARE UNIT	31,082	2,374,767	19,623	2,394,390	555	31.00
43.00	04300	NURSERY	24	1,845	15	1,860	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	69,411	5,303,207	43,820	5,347,027	1,241	50.00
51.00	05100	RECOVERY ROOM	6,870	524,868	4,337	529,205	123	51.00
53.00	05300	ANESTHESIOLOGY	1,174	89,734	741	90,475	21	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	52,984	4,048,145	33,450	4,081,595	947	54.00
57.00	05700	CT SCAN	8,023	613,010	5,065	618,075	143	57.00
58.00	05800	MRI	2,943	224,847	1,858	226,705	53	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,043	538,145	4,447	542,592	126	59.00
60.00	06000	LABORATORY	58,654	4,481,400	37,030	4,518,430	1,048	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,529	193,191	1,596	194,787	45	62.00
64.00	06400	INTRAVENOUS THERAPY	11,677	892,138	7,372	899,510	209	64.00
65.00	06500	RESPIRATORY THERAPY	13,974	1,067,624	8,822	1,076,446	250	65.00
66.00	06600	PHYSICAL THERAPY	16,467	1,258,155	10,396	1,268,551	294	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,772	593,842	4,907	598,749	139	67.00
68.00	06800	SPEECH PATHOLOGY	4,686	358,018	2,958	360,976	84	68.00
69.00	06900	ELECTROCARDIOLOGY	5,661	432,496	3,574	436,070	101	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,901	374,458	3,094	377,552	88	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	26,638	2,035,243	16,817	2,052,060	476	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,281	1,549,545	12,804	1,562,349	362	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	121,014	9,245,888	76,399	9,322,287	2,163	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	8,929	682,232	5,637	687,869	160	76.03
76.04	03952	PAIN CLINIC	2,378	181,707	1,501	183,208	43	76.04
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	44,213	3,378,053	27,913	3,405,966	790	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		0		92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	936,627	71,561,485	586,357	71,550,345	16,587	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	81	6,208	51	6,259	1	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,691	740,390	6,118	746,508	173	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FUND DEVELOPMENT	1,392	106,328	879	107,207	25	193.02
193.05	19305	EMS	1,216	92,909	768	93,677	22	193.05
193.07	19307	SAINT CLARE'S VILLA	75	5,761	48	5,809	1	193.07
194.00	07950	UNUSED SPACE	5,189	396,487	3,276	399,763	93	194.00
200.00		Cross Foot Adjustments		0		0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	954,271	72,909,568	597,497	72,909,568	16,902	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0052

Period:
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Cost Center Description			Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5A.04	5.05	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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	14,683,060	14,683,060				5.05
7.00	00700	OPERATION OF PLANT	4,491,344	1,132,587	5,623,931			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	250,759	63,234	26,305	340,298		8.00
9.00	00900	HOUSEKEEPING	1,479,029	372,968	186,809	0	2,038,806	9.00
10.00	01000	DIETARY	736,606	185,751	172,209	0	64,889	10.00
11.00	01100	CAFETERIA	742,235	187,170	112,418	0	42,359	11.00
13.00	01300	NURSING ADMINISTRATION	1,774,473	447,471	24,214	0	9,124	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	281,545	70,997	187,649	0	70,706	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	914,474	230,604	54,752	0	20,631	16.00
17.00	01700	SOCIAL SERVICE	471,463	118,889	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,938,847	1,245,434	790,764	110,651	297,961	30.00
31.00	03100	INTENSIVE CARE UNIT	2,394,945	603,936	260,446	24,991	98,137	31.00
43.00	04300	NURSERY	1,860	469	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,348,268	1,348,678	420,591	55,208	158,479	50.00
51.00	05100	RECOVERY ROOM	529,328	133,481	17,051	0	6,425	51.00
53.00	05300	ANESTHESIOLOGY	90,496	22,820	1,731	0	652	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,082,542	1,029,499	174,162	42,853	65,625	54.00
57.00	05700	CT SCAN	618,218	155,897	16,040	0	6,044	57.00
58.00	05800	MRI	226,758	57,182	13,795	0	5,198	58.00
59.00	05900	CARDIAC CATHETERIZATION	542,718	136,858	38,130	18,402	14,367	59.00
60.00	06000	LABORATORY	4,519,478	1,139,681	247,028	0	93,081	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	194,832	49,131	7,969	0	3,003	62.00
64.00	06400	INTRAVENOUS THERAPY	899,719	226,883	94,407	3,974	35,573	64.00
65.00	06500	RESPIRATORY THERAPY	1,076,696	271,512	37,393	0	14,090	65.00
66.00	06600	PHYSICAL THERAPY	1,268,845	319,966	166,553	9,633	62,758	66.00
67.00	06700	OCCUPATIONAL THERAPY	598,888	151,022	128,886	0	48,565	67.00
68.00	06800	SPEECH PATHOLOGY	361,060	91,049	18,645	0	7,025	68.00
69.00	06900	ELECTROCARDIOLOGY	436,171	109,990	51,942	0	19,572	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	377,640	95,230	64,795	300	24,415	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,052,536	517,590	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,562,711	394,070	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,324,450	2,351,378	61,436	0	23,149	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	688,029	173,501	38,112	0	14,361	76.03
76.04	03952	PAIN CLINIC	183,251	46,211	8,688	0	3,274	76.04
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	3,406,756	859,085	226,567	74,286	85,371	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)	71,550,030	14,340,224	3,649,487	340,298	1,294,834	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,260	1,579	15,629	0	5,889	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	746,681	188,291	820,308	0	309,094	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FUND DEVELOPMENT	107,232	27,041	0	0	0	193.02
193.05	19305	EMS	93,699	23,628	2,673	0	1,007	193.05
193.07	19307	SAINT CLARE'S VILLA	5,810	1,465	0	0	0	193.07
194.00	07950	UNUSED SPACE	399,856	100,832	1,135,834	0	427,982	194.00
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	72,909,568	14,683,060	5,623,931	340,298	2,038,806	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0052

Period:
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	14.00	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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						5.05
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	1,159,455					10.00
11.00	01100	CAFETERIA	0	1,084,182				11.00
13.00	01300	NURSING ADMINISTRATION	0	36,229	2,291,511			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,357	0	616,254		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	2	1,220,463	16.00
17.00	01700	SOCIAL SERVICE	0	37,740	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	961,985	183,033	874,245	14,710	30,002	30.00
31.00	03100	INTENSIVE CARE UNIT	161,730	62,155	233,774	8,033	10,783	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,856	150,306	545,120	0	152,158	50.00
51.00	05100	RECOVERY ROOM	0	14,182	73,374	3,817	20,498	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	7,274	14,674	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	102,642	35,874	32,021	107,686	54.00
57.00	05700	CT SCAN	0	13,461	0	9,856	139,108	57.00
58.00	05800	MRI	0	6,902	0	3,172	20,581	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	17,960	53,881	0	25,330	59.00
60.00	06000	LABORATORY	0	112,292	0	14,171	137,030	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	21,898	3,927	62.00
64.00	06400	INTRAVENOUS THERAPY	0	32,383	75,053	6,696	12,190	64.00
65.00	06500	RESPIRATORY THERAPY	0	36,091	0	15,060	19,254	65.00
66.00	06600	PHYSICAL THERAPY	0	37,019	0	668	29,340	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	18,784	0	151	8,552	67.00
68.00	06800	SPEECH PATHOLOGY	0	9,478	0	0	2,458	68.00
69.00	06900	ELECTROCARDIOLOGY	0	11,057	19,817	485	44,490	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,769	0	416	19,706	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	259,287	47,530	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	180,721	30,734	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	35,714	0	5,965	229,124	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	25,274	0	3	3,864	76.03
76.04	03952	PAIN CLINIC	0	7,555	7,547	2,477	5,750	76.04
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	28,884	116,893	372,826	29,251	105,694	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,159,455	1,078,276	2,291,511	616,134	1,220,463	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	8	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,438	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FUND DEVELOPMENT	0	0	0	0	0	193.02
193.05	19305	EMS	0	3,468	0	98	0	193.05
193.07	19307	SAINT CLARE'S VILLA	0	0	0	14	0	193.07
194.00	07950	UNUSED SPACE	0	0	0	0	0	194.00
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)	1,159,455	1,084,182	2,291,511	616,254	1,220,463	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0052

Period:
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Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL					5.05
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
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	628,092				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	553,031	10,000,663	0	10,000,663	30.00
31.00	03100	INTENSIVE CARE UNIT	75,061	3,933,991	0	3,933,991	31.00
43.00	04300	NURSERY	0	2,329	0	2,329	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	8,185,664	0	8,185,664	50.00
51.00	05100	RECOVERY ROOM	0	798,156	0	798,156	51.00
53.00	05300	ANESTHESIOLOGY	0	137,647	0	137,647	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,672,904	0	5,672,904	54.00
57.00	05700	CT SCAN	0	958,624	0	958,624	57.00
58.00	05800	MRI	0	333,588	0	333,588	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	847,646	0	847,646	59.00
60.00	06000	LABORATORY	0	6,262,761	0	6,262,761	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	280,760	0	280,760	62.00
64.00	06400	INTRAVENOUS THERAPY	0	1,386,878	0	1,386,878	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,470,096	0	1,470,096	65.00
66.00	06600	PHYSICAL THERAPY	0	1,894,782	0	1,894,782	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	954,848	0	954,848	67.00
68.00	06800	SPEECH PATHOLOGY	0	489,715	0	489,715	68.00
69.00	06900	ELECTROCARDIOLOGY	0	693,524	0	693,524	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	588,271	0	588,271	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,876,943	0	2,876,943	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,168,236	0	2,168,236	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,031,216	0	12,031,216	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	943,144	0	943,144	76.03
76.04	03952	PAIN CLINIC	0	264,753	0	264,753	76.04
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	5,305,613	0	5,305,613	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)	628,092	68,482,752	0	68,482,752	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	29,365	0	29,365	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,066,812	0	2,066,812	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.02	19302	FUND DEVELOPMENT	0	134,273	0	134,273	193.02
193.05	19305	EMS	0	124,573	0	124,573	193.05
193.07	19307	SAINT CLARE'S VILLA	0	7,289	0	7,289	193.07
194.00	07950	UNUSED SPACE	0	2,064,504	0	2,064,504	194.00
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	628,092	72,909,568	0	72,909,568	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0052

Period:
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To 09/30/2019Worksheet B
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	8,035	36	8,071	4.00
5.01	00540	NONPATIENT TELEPHONES	0	4,451	12,572	17,023	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	32,205	218	32,423	5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	15,096	0	15,096	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	20,670	574,007	530,660	1,125,337	5.05
7.00	00700	OPERATION OF PLANT	0	221,926	60,965	282,891	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	9,044	0	9,044	8.00
9.00	00900	HOUSEKEEPING	0	64,356	4,172	68,528	9.00
10.00	01000	DIETARY	0	59,326	6,226	65,552	10.00
11.00	01100	CAFETERIA	0	38,728	23,870	62,598	11.00
13.00	01300	NURSING ADMINISTRATION	0	8,324	79,910	88,234	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	64,646	22,330	86,976	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	18,862	0	18,862	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	57,407	272,421	94,325	424,153	30.00
31.00	03100	INTENSIVE CARE UNIT	13,243	89,725	131,802	234,770	31.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,829	144,895	620,127	774,851	50.00
51.00	05100	RECOVERY ROOM	0	5,856	18,739	24,595	51.00
53.00	05300	ANESTHESIOLOGY	0	596	23,015	23,611	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	59,769	222,698	282,467	54.00
57.00	05700	CT SCAN	0	5,526	8,706	14,232	57.00
58.00	05800	MRI	0	4,752	669	5,421	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	13,136	17,264	30,400	59.00
60.00	06000	LABORATORY	37,264	85,102	85,961	208,327	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	2,745	1,771	4,516	62.00
64.00	06400	INTRAVENOUS THERAPY	0	32,524	6,069	38,593	64.00
65.00	06500	RESPIRATORY THERAPY	3,981	12,864	15,640	32,485	65.00
66.00	06600	PHYSICAL THERAPY	0	57,378	11,712	69,090	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	44,402	10,418	54,820	67.00
68.00	06800	SPEECH PATHOLOGY	0	6,423	23,977	30,400	68.00
69.00	06900	ELECTROCARDIOLOGY	0	17,882	57,737	75,619	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	22,316	3,445	25,761	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	21,165	42,402	63,567	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	13,130	1,234	14,364	76.03
76.04	03952	PAIN CLINIC	0	2,993	1,421	4,414	76.04
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	77,958	48,212	126,170	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)	142,394	2,112,564	2,188,303	4,443,261	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,384	0	5,384	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	162,988	282,599	47,045	492,632	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.02	19302	FUND DEVELOPMENT	0	0	0	0	193.02
193.05	19305	EMS	0	921	1,231	2,152	193.05
193.07	19307	SAINT CLARE'S VILLA	0	0	0	0	193.07
194.00	07950	UNUSED SPACE	0	391,298	0	391,298	194.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	305,382	2,792,766	2,236,579	5,334,727	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0052

Period:
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Cost Center Description			NONPATIENT TELEPHONES	PURCHASING RECEIVING AND STORES	CASHIERING/ACC OUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	
			5.01	5.02	5.04	5.05	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	17,231					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	141	32,670				5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	4	8	15,108			5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	3,468	6,566	3,059	1,139,029		5.05
7.00	00700	OPERATION OF PLANT	1,050	2,013	929	87,860	375,082	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	59	112	52	4,905	1,754	8.00
9.00	00900	HOUSEKEEPING	346	663	306	28,933	12,459	9.00
10.00	01000	DIETARY	172	330	152	14,409	11,485	10.00
11.00	01100	CAFETERIA	174	333	154	14,520	7,498	11.00
13.00	01300	NURSING ADMINISTRATION	415	795	367	34,712	1,615	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	66	126	58	5,508	12,515	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	214	410	189	17,889	3,652	16.00
17.00	01700	SOCIAL SERVICE	110	211	98	9,223	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,155	2,214	1,022	96,614	52,739	30.00
31.00	03100	INTENSIVE CARE UNIT	560	1,073	496	46,850	17,370	31.00
43.00	04300	NURSERY	0	1	0	36	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,251	2,397	1,107	104,623	28,051	50.00
51.00	05100	RECOVERY ROOM	124	237	110	10,355	1,137	51.00
53.00	05300	ANESTHESIOLOGY	21	41	19	1,770	115	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	955	1,830	845	79,863	11,616	54.00
57.00	05700	CT SCAN	145	277	128	12,094	1,070	57.00
58.00	05800	MRI	53	102	47	4,436	920	58.00
59.00	05900	CARDIAC CATHETERIZATION	127	243	112	10,617	2,543	59.00
60.00	06000	LABORATORY	1,057	2,026	935	88,410	16,475	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	46	87	40	3,811	531	62.00
64.00	06400	INTRAVENOUS THERAPY	210	403	186	17,600	6,296	64.00
65.00	06500	RESPIRATORY THERAPY	252	483	223	21,062	2,494	65.00
66.00	06600	PHYSICAL THERAPY	297	569	263	24,821	11,108	66.00
67.00	06700	OCCUPATIONAL THERAPY	140	268	124	11,715	8,596	67.00
68.00	06800	SPEECH PATHOLOGY	84	162	75	7,063	1,244	68.00
69.00	06900	ELECTROCARDIOLOGY	102	195	90	8,532	3,464	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	88	169	78	7,387	4,321	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	480	920	425	40,152	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	365	700	323	30,570	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,181	4,179	1,930	182,406	4,097	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	161	308	142	13,459	2,542	76.03
76.04	03952	PAIN CLINIC	43	82	38	3,585	579	76.04
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	797	1,527	705	66,643	15,111	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)	16,913	32,060	14,827	1,112,433	243,397	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1	3	1	122	1,042	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	175	335	155	14,607	54,710	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FUND DEVELOPMENT	25	48	22	2,098	0	193.02
193.05	19305	EMS	22	42	19	1,833	178	193.05
193.07	19307	SAINT CLARE'S VILLA	1	3	1	114	0	193.07
194.00	07950	UNUSED SPACE	94	179	83	7,822	75,755	194.00
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)	17,231	32,670	15,108	1,139,029	375,082	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0052

Period:
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Cost Center Description			LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,928					8.00
9.00	00900	HOUSEKEEPING	0	111,504				9.00
10.00	01000	DIETARY	0	3,549	95,779			10.00
11.00	01100	CAFETERIA	0	2,317	0	87,729		11.00
13.00	01300	NURSING ADMINISTRATION	0	499	0	2,932	129,845	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,867	0	433	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,128	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	3,054	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,179	16,296	79,467	14,811	49,537	30.00
31.00	03100	INTENSIVE CARE UNIT	1,170	5,367	13,360	5,029	13,246	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,584	8,667	566	12,162	30,888	50.00
51.00	05100	RECOVERY ROOM	0	351	0	1,148	4,158	51.00
53.00	05300	ANESTHESIOLOGY	0	36	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,006	3,589	0	8,306	2,033	54.00
57.00	05700	CT SCAN	0	331	0	1,089	0	57.00
58.00	05800	MRI	0	284	0	559	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	861	786	0	1,453	3,053	59.00
60.00	06000	LABORATORY	0	5,091	0	9,086	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	164	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	186	1,946	0	2,620	4,253	64.00
65.00	06500	RESPIRATORY THERAPY	0	771	0	2,920	0	65.00
66.00	06600	PHYSICAL THERAPY	451	3,432	0	2,995	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,656	0	1,520	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	384	0	767	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,070	0	895	1,123	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14	1,335	0	467	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	1,266	0	2,890	0	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	785	0	2,045	0	76.03
76.04	03952	PAIN CLINIC	0	179	0	611	428	76.04
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	3,477	4,669	2,386	9,459	21,126	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)	15,928	70,815	95,779	87,251	129,845	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	322	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	16,905	0	197	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FUND DEVELOPMENT	0	0	0	0	0	193.02
193.05	19305	EMS	0	55	0	281	0	193.05
193.07	19307	SAINT CLARE'S VILLA	0	0	0	0	0	193.07
194.00	07950	UNUSED SPACE	0	23,407	0	0	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	15,928	111,504	95,779	87,729	129,845	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						5.05
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	109,570					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	42,514				16.00
17.00	01700	SOCIAL SERVICE	0	0	12,696			17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,616	1,046	11,179	758,977	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,428	376	1,517	342,972	0	31.00
43.00	04300	NURSERY	0	0	0	37	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	5,303	0	973,395	0	50.00
51.00	05100	RECOVERY ROOM	679	714	0	43,716	0	51.00
53.00	05300	ANESTHESIOLOGY	1,293	511	0	27,417	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,694	3,753	0	403,541	0	54.00
57.00	05700	CT SCAN	1,752	4,848	0	36,044	0	57.00
58.00	05800	MRI	564	717	0	13,147	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	883	0	51,198	0	59.00
60.00	06000	LABORATORY	2,520	4,776	0	339,241	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	3,894	137	0	13,226	0	62.00
64.00	06400	INTRAVENOUS THERAPY	1,191	425	0	74,082	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,678	671	0	64,246	0	65.00
66.00	06600	PHYSICAL THERAPY	119	1,023	0	114,429	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	27	298	0	80,284	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	86	0	40,339	0	68.00
69.00	06900	ELECTROCARDIOLOGY	86	1,551	0	92,808	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	74	687	0	40,412	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	46,098	1,657	0	89,732	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,133	1,071	0	65,162	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,061	7,962	0	271,827	0	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1	135	0	34,097	0	76.03
76.04	03952	PAIN CLINIC	440	200	0	10,634	0	76.04
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	5,201	3,684	0	261,596	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)	109,549	42,514	12,696	4,242,559	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1	0	0	6,876	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	579,723	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FUND DEVELOPMENT	0	0	0	2,193	0	193.02
193.05	19305	EMS	17	0	0	4,616	0	193.05
193.07	19307	SAINT CLARE'S VILLA	3	0	0	122	0	193.07
194.00	07950	UNUSED SPACE	0	0	0	498,638	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	109,570	42,514	12,696	5,334,727	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0052

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/20/2020 8:51 am

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00540	NONPATIENT TELEPHONES	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	5.05
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
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.03
76.04	03952	PAIN CLINIC	76.04
OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	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)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
193.00	19300	NONPAID WORKERS	193.00
193.02	19302	FUND DEVELOPMENT	193.02
193.05	19305	EMS	193.05
193.07	19307	SAINT CLARE'S VILLA	193.07
194.00	07950	UNUSED SPACE	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0052

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/20/2020 8:51 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	NONPATIENT TELEPHONES (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00	4.00	5A.01	5.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	473,053				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,006,910			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,361	32	25,150,376		4.00
5.01	00540	NONPATIENT TELEPHONES	754	11,281	649,332	-954,271	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	5,455	196	330,705	0	5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,557	0	0	0	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	97,228	476,168	1,865,349	0	5.05
7.00	00700	OPERATION OF PLANT	37,591	54,705	1,054,881	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,532	0	5,461	0	8.00
9.00	00900	HOUSEKEEPING	10,901	3,744	838,424	0	9.00
10.00	01000	DIETARY	10,049	5,587	405,876	0	10.00
11.00	01100	CAFETERIA	6,560	21,419	419,121	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,410	71,704	861,031	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,950	20,037	66,807	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,195	0	529,280	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	46,144	84,639	2,963,648	0	30.00
31.00	03100	INTENSIVE CARE UNIT	15,198	118,268	1,121,693	0	31.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	24,543	556,446	2,942,380	0	50.00
51.00	05100	RECOVERY ROOM	992	16,815	335,634	0	51.00
53.00	05300	ANESTHESIOLOGY	101	20,652	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,124	199,830	1,819,993	0	54.00
57.00	05700	CT SCAN	936	7,812	241,831	0	57.00
58.00	05800	MRI	805	600	137,495	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,225	15,491	375,334	0	59.00
60.00	06000	LABORATORY	14,415	77,134	1,674,699	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	465	1,589	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	5,509	5,446	538,972	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,179	14,034	645,560	0	65.00
66.00	06600	PHYSICAL THERAPY	9,719	10,509	813,582	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,521	9,348	375,320	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,088	21,515	229,426	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,029	51,808	251,394	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,780	3,091	95,623	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	3,585	38,048	897,369	0	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,224	1,107	483,771	0	76.03
76.04	03952	PAIN CLINIC	507	1,275	107,494	0	76.04
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	13,205	43,261	1,998,161	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)	357,837	1,963,591	25,075,646	-954,271	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	912	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	47,868	42,214	21,617	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.02	19302	FUND DEVELOPMENT	0	0	0	0	193.02
193.05	19305	EMS	156	1,105	53,113	0	193.05
193.07	19307	SAINT CLARE'S VILLA	0	0	0	0	193.07
194.00	07950	UNUSED SPACE	66,280	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,792,766	2,236,579	8,806,610	954,271	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.903706	1.114439	0.350158	0.013262	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			8,071	17,231	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000321	0.000239	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0052

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/20/2020 8:51 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	NONPATIENT TELEPHONES (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A.01	5.01	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0052

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/20/2020 8:51 am

Cost Center Description		Reconciliation	PURCHASING RECEIVING AND STORES (ACCUM. COST)	Reconciliation	CASHIERING/ACC OUNTS RECEIVABLE (ACCUM. COST)	Reconciliation	
		5A.02	5.02	5A.04	5.04	5A.05	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	-597,497	72,312,071			5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	16,763	-16,902	72,892,666	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	0	14,559,378	0	14,679,664	5.05
7.00	00700	OPERATION OF PLANT	0	4,453,503	0	4,490,302	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	248,646	0	250,701	8.00
9.00	00900	HOUSEKEEPING	0	1,466,568	0	1,478,686	9.00
10.00	01000	DIETARY	0	730,400	0	736,435	10.00
11.00	01100	CAFETERIA	0	735,982	0	742,063	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,759,522	0	1,774,061	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	279,173	0	281,480	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	906,769	0	914,262	16.00
17.00	01700	SOCIAL SERVICE	0	467,491	0	471,354	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	4,897,235	0	4,937,701	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,374,767	0	2,394,390	31.00
43.00	04300	NURSERY	0	1,845	0	1,860	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	5,303,207	0	5,347,027	50.00
51.00	05100	RECOVERY ROOM	0	524,868	0	529,205	51.00
53.00	05300	ANESTHESIOLOGY	0	89,734	0	90,475	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,048,145	0	4,081,595	54.00
57.00	05700	CT SCAN	0	613,010	0	618,075	57.00
58.00	05800	MRI	0	224,847	0	226,705	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	538,145	0	542,592	59.00
60.00	06000	LABORATORY	0	4,481,400	0	4,518,430	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	193,191	0	194,787	62.00
64.00	06400	INTRAVENOUS THERAPY	0	892,138	0	899,510	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,067,624	0	1,076,446	65.00
66.00	06600	PHYSICAL THERAPY	0	1,258,155	0	1,268,551	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	593,842	0	598,749	67.00
68.00	06800	SPEECH PATHOLOGY	0	358,018	0	360,976	68.00
69.00	06900	ELECTROCARDIOLOGY	0	432,496	0	436,070	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	374,458	0	377,552	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,035,243	0	2,052,060	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,549,545	0	1,562,349	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,245,888	0	9,322,287	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	682,232	0	687,869	76.03
76.04	03952	PAIN CLINIC	0	181,707	0	183,208	76.04
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	3,378,053	0	3,405,966	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)	-597,497	70,963,988	-16,902	71,533,443	-14,683,060
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,208	0	6,259	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	740,390	0	746,508	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.02	19302	FUND DEVELOPMENT	0	106,328	0	107,207	193.02
193.05	19305	EMS	0	92,909	0	93,677	193.05
193.07	19307	SAINT CLARE'S VILLA	0	5,761	0	5,809	193.07
194.00	07950	UNUSED SPACE	0	396,487	0	399,763	194.00
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)		597,497		16,902	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.008263		0.000232	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		32,670		15,108	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000452		0.000207	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: 14-0052

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/20/2020 8:51 am

Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT ME ALS)	
		5.05	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
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	58,226,508				5.05
7.00	00700	OPERATION OF PLANT	4,491,344	328,177			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	250,759	1,535	370,874		8.00
9.00	00900	HOUSEKEEPING	1,479,029	10,901	0	315,741	9.00
10.00	01000	DIETARY	736,606	10,049	0	10,049	10.00
11.00	01100	CAFETERIA	742,235	6,560	0	6,560	11.00
13.00	01300	NURSING ADMINISTRATION	1,774,473	1,413	0	1,413	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	281,545	10,950	0	10,950	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	914,474	3,195	0	3,195	16.00
17.00	01700	SOCIAL SERVICE	471,463	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,938,847	46,144	120,595	46,144	30.00
31.00	03100	INTENSIVE CARE UNIT	2,394,945	15,198	27,236	15,198	31.00
43.00	04300	NURSERY	1,860	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,348,268	24,543	60,168	24,543	50.00
51.00	05100	RECOVERY ROOM	529,328	995	0	995	51.00
53.00	05300	ANESTHESIOLOGY	90,496	101	0	101	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,082,542	10,163	46,703	10,163	54.00
57.00	05700	CT SCAN	618,218	936	0	936	57.00
58.00	05800	MRI	226,758	805	0	805	58.00
59.00	05900	CARDIAC CATHETERIZATION	542,718	2,225	20,055	2,225	59.00
60.00	06000	LABORATORY	4,519,478	14,415	0	14,415	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	194,832	465	0	465	62.00
64.00	06400	INTRAVENOUS THERAPY	899,719	5,509	4,331	5,509	64.00
65.00	06500	RESPIRATORY THERAPY	1,076,696	2,182	0	2,182	65.00
66.00	06600	PHYSICAL THERAPY	1,268,845	9,719	10,498	9,719	66.00
67.00	06700	OCCUPATIONAL THERAPY	598,888	7,521	0	7,521	67.00
68.00	06800	SPEECH PATHOLOGY	361,060	1,088	0	1,088	68.00
69.00	06900	ELECTROCARDIOLOGY	436,171	3,031	0	3,031	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	377,640	3,781	327	3,781	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,052,536	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,562,711	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,324,450	3,585	0	3,585	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	688,029	2,224	0	2,224	76.03
76.04	03952	PAIN CLINIC	183,251	507	0	507	76.04
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	3,406,756	13,221	80,961	13,221	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)	56,866,970	212,961	370,874	200,525	30,949
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,260	912	0	912	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	746,681	47,868	0	47,868	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.02	19302	FUND DEVELOPMENT	107,232	0	0	0	193.02
193.05	19305	EMS	93,699	156	0	156	193.05
193.07	19307	SAINT CLARE'S VILLA	5,810	0	0	0	193.07
194.00	07950	UNUSED SPACE	399,856	66,280	0	66,280	194.00
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)	14,683,060	5,623,931	340,298	2,038,806	1,159,455
203.00		Unit cost multiplier (Wkst. B, Part I)	0.252171	17.136883	0.917557	6.457210	37.463408
204.00		Cost to be allocated (per Wkst. B, Part II)	1,139,029	375,082	15,928	111,504	95,779
205.00		Unit cost multiplier (Wkst. B, Part II)	0.019562	1.142926	0.042947	0.353150	3.094737
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: 14-0052

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/20/2020 8:51 am

Cost Center Description			CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (PURCHASE R EQUIS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
			11.00	13.00	14.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						5.05
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	31,572					11.00
13.00	01300	NURSING ADMINISTRATION	1,055	262,024				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	156	0	5,214,759			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	21	397,595,403		16.00
17.00	01700	SOCIAL SERVICE	1,099	0	0	0	9,330	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,330	99,966	124,478	9,772,562	8,215	30.00
31.00	03100	INTENSIVE CARE UNIT	1,810	26,731	67,975	3,512,497	1,115	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,377	62,332	0	49,562,819	0	50.00
51.00	05100	RECOVERY ROOM	413	8,390	32,303	6,676,957	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	61,549	4,779,657	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,989	4,102	270,965	35,076,922	0	54.00
57.00	05700	CT SCAN	392	0	83,404	45,311,915	0	57.00
58.00	05800	MRI	201	0	26,839	6,704,040	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	523	6,161	0	8,250,797	0	59.00
60.00	06000	LABORATORY	3,270	0	119,912	44,635,118	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	185,300	1,279,276	0	62.00
64.00	06400	INTRAVENOUS THERAPY	943	8,582	56,665	3,970,637	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,051	0	127,441	6,271,805	0	65.00
66.00	06600	PHYSICAL THERAPY	1,078	0	5,653	9,556,855	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	547	0	1,278	2,785,604	0	67.00
68.00	06800	SPEECH PATHOLOGY	276	0	0	800,806	0	68.00
69.00	06900	ELECTROCARDIOLOGY	322	2,266	4,100	14,491,789	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	168	0	3,518	6,418,822	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	2,194,095	15,481,971	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,529,264	10,010,949	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,040	0	50,472	74,684,117	0	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	736	0	29	1,258,473	0	76.03
76.04	03952	PAIN CLINIC	220	863	20,960	1,873,045	0	76.04
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	3,404	42,631	247,524	34,427,970	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)	31,400	262,024	5,213,745	397,595,403	9,330	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	65	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	71	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FUND DEVELOPMENT	0	0	0	0	0	193.02
193.05	19305	EMS	101	0	828	0	0	193.05
193.07	19307	SAINT CLARE'S VILLA	0	0	121	0	0	193.07
194.00	07950	UNUSED SPACE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,084,182	2,291,511	616,254	1,220,463	628,092	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	34.339985	8.745424	0.118175	0.003070	67.319614	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	87,729	129,845	109,570	42,514	12,696	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.778696	0.495546	0.021012	0.000107	1.360772	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0052

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/20/2020 8:51 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	10,000,663		10,000,663	0	10,000,663	30.00	
31.00	03100	INTENSIVE CARE UNIT	3,933,991		3,933,991	0	3,933,991	31.00	
43.00	04300	NURSERY	2,329		2,329	0	2,329	43.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	8,185,664		8,185,664	0	8,185,664	50.00	
51.00	05100	RECOVERY ROOM	798,156		798,156	0	798,156	51.00	
53.00	05300	ANESTHESIOLOGY	137,647		137,647	0	137,647	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,672,904		5,672,904	0	5,672,904	54.00	
57.00	05700	CT SCAN	958,624		958,624	0	958,624	57.00	
58.00	05800	MRI	333,588		333,588	0	333,588	58.00	
59.00	05900	CARDIAC CATHETERIZATION	847,646		847,646	0	847,646	59.00	
60.00	06000	LABORATORY	6,262,761		6,262,761	6,960	6,269,721	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	280,760		280,760	0	280,760	62.00	
64.00	06400	INTRAVENOUS THERAPY	1,386,878		1,386,878	0	1,386,878	64.00	
65.00	06500	RESPIRATORY THERAPY	1,470,096	0	1,470,096	0	1,470,096	65.00	
66.00	06600	PHYSICAL THERAPY	1,894,782	0	1,894,782	0	1,894,782	66.00	
67.00	06700	OCCUPATIONAL THERAPY	954,848	0	954,848	0	954,848	67.00	
68.00	06800	SPEECH PATHOLOGY	489,715	0	489,715	0	489,715	68.00	
69.00	06900	ELECTROCARDIOLOGY	693,524		693,524	0	693,524	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	588,271		588,271	0	588,271	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,876,943		2,876,943	0	2,876,943	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,168,236		2,168,236	0	2,168,236	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	12,031,216		12,031,216	0	12,031,216	73.00	
76.00	03950	THERAPEUTIC ACTIVITIES	0		0	0	0	76.00	
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	943,144		943,144	0	943,144	76.03	
76.04	03952	PAIN CLINIC	264,753		264,753	0	264,753	76.04	
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	5,305,613		5,305,613	0	5,305,613	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,410,595		1,410,595		1,410,595	92.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	69,893,347	0	69,893,347	6,960	69,900,307	200.00	
201.00		Less Observation Beds	1,410,595		1,410,595		1,410,595	201.00	
202.00		Total (see instructions)	68,482,752	0	68,482,752	6,960	68,489,712	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0052

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/20/2020 8:51 am

			Title XVIII			Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,693,139		7,693,139			30.00
31.00	03100	INTENSIVE CARE UNIT	3,512,497		3,512,497			31.00
43.00	04300	NURSERY	0		0			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,396,357	40,166,462	49,562,819	0.165157	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,637,016	5,039,941	6,676,957	0.119539	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	1,198,876	3,580,781	4,779,657	0.028799	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,324,383	30,752,539	35,076,922	0.161728	0.000000	54.00
57.00	05700	CT SCAN	9,326,015	35,985,900	45,311,915	0.021156	0.000000	57.00
58.00	05800	MRI	1,265,787	5,438,253	6,704,040	0.049759	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,739,232	4,511,565	8,250,797	0.102735	0.000000	59.00
60.00	06000	LABORATORY	12,655,370	31,979,748	44,635,118	0.140310	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	755,975	523,301	1,279,276	0.219468	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	19,081	3,951,556	3,970,637	0.349284	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	3,732,312	2,539,493	6,271,805	0.234398	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,027,657	8,529,198	9,556,855	0.198264	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,088,223	1,697,381	2,785,604	0.342780	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	183,481	617,325	800,806	0.611528	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	5,095,170	9,396,619	14,491,789	0.047856	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	175,580	6,243,242	6,418,822	0.091648	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,514,860	9,967,111	15,481,971	0.185825	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,231,370	4,779,579	10,010,949	0.216586	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,612,591	62,071,526	74,684,117	0.161095	0.000000	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0.000000	0.000000	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	210	1,258,263	1,258,473	0.749435	0.000000	76.03
76.04	03952	PAIN CLINIC	19,801	1,853,244	1,873,045	0.141349	0.000000	76.04
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	5,347,670	29,080,300	34,427,970	0.154108	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	752,241	1,327,182	2,079,423	0.678359	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	96,304,894	301,290,509	397,595,403			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	96,304,894	301,290,509	397,595,403			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0052

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/20/2020 8:51 am

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.165157			50.00
51.00	05100	RECOVERY ROOM	0.119539			51.00
53.00	05300	ANESTHESIOLOGY	0.028799			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161728			54.00
57.00	05700	CT SCAN	0.021156			57.00
58.00	05800	MRI	0.049759			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.102735			59.00
60.00	06000	LABORATORY	0.140466			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.219468			62.00
64.00	06400	INTRAVENOUS THERAPY	0.349284			64.00
65.00	06500	RESPIRATORY THERAPY	0.234398			65.00
66.00	06600	PHYSICAL THERAPY	0.198264			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.342780			67.00
68.00	06800	SPEECH PATHOLOGY	0.611528			68.00
69.00	06900	ELECTROCARDIOLOGY	0.047856			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.091648			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.185825			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.216586			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.161095			73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0.000000			76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.749435			76.03
76.04	03952	PAIN CLINIC	0.141349			76.04
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.154108			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.678359			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: 14-0052

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/20/2020 8:51 am

				Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	10,000,663		10,000,663	0	10,000,663	30.00	
31.00	03100	INTENSIVE CARE UNIT	3,933,991		3,933,991	0	3,933,991	31.00	
43.00	04300	NURSERY	2,329		2,329	0	2,329	43.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	8,185,664		8,185,664	0	8,185,664	50.00	
51.00	05100	RECOVERY ROOM	798,156		798,156	0	798,156	51.00	
53.00	05300	ANESTHESIOLOGY	137,647		137,647	0	137,647	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,672,904		5,672,904	0	5,672,904	54.00	
57.00	05700	CT SCAN	958,624		958,624	0	958,624	57.00	
58.00	05800	MRI	333,588		333,588	0	333,588	58.00	
59.00	05900	CARDIAC CATHETERIZATION	847,646		847,646	0	847,646	59.00	
60.00	06000	LABORATORY	6,262,761		6,262,761	6,960	6,269,721	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	280,760		280,760	0	280,760	62.00	
64.00	06400	INTRAVENOUS THERAPY	1,386,878		1,386,878	0	1,386,878	64.00	
65.00	06500	RESPIRATORY THERAPY	1,470,096	0	1,470,096	0	1,470,096	65.00	
66.00	06600	PHYSICAL THERAPY	1,894,782	0	1,894,782	0	1,894,782	66.00	
67.00	06700	OCCUPATIONAL THERAPY	954,848	0	954,848	0	954,848	67.00	
68.00	06800	SPEECH PATHOLOGY	489,715	0	489,715	0	489,715	68.00	
69.00	06900	ELECTROCARDIOLOGY	693,524		693,524	0	693,524	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	588,271		588,271	0	588,271	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,876,943		2,876,943	0	2,876,943	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,168,236		2,168,236	0	2,168,236	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	12,031,216		12,031,216	0	12,031,216	73.00	
76.00	03950	THERAPEUTIC ACTIVITIES	0		0	0	0	76.00	
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	943,144		943,144	0	943,144	76.03	
76.04	03952	PAIN CLINIC	264,753		264,753	0	264,753	76.04	
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	5,305,613		5,305,613	0	5,305,613	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,410,595		1,410,595		1,410,595	92.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	69,893,347	0	69,893,347	6,960	69,900,307	200.00	
201.00		Less Observation Beds	1,410,595		1,410,595		1,410,595	201.00	
202.00		Total (see instructions)	68,482,752	0	68,482,752	6,960	68,489,712	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0052

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/20/2020 8:51 am

			Title XIX			Hospital	Cost	
	Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,693,139		7,693,139			30.00
31.00	03100	INTENSIVE CARE UNIT	3,512,497		3,512,497			31.00
43.00	04300	NURSERY	0		0			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,396,357	40,166,462	49,562,819	0.165157	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,637,016	5,039,941	6,676,957	0.119539	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	1,198,876	3,580,781	4,779,657	0.028799	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,324,383	30,752,539	35,076,922	0.161728	0.000000	54.00
57.00	05700	CT SCAN	9,326,015	35,985,900	45,311,915	0.021156	0.000000	57.00
58.00	05800	MRI	1,265,787	5,438,253	6,704,040	0.049759	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,739,232	4,511,565	8,250,797	0.102735	0.000000	59.00
60.00	06000	LABORATORY	12,655,370	31,979,748	44,635,118	0.140310	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	755,975	523,301	1,279,276	0.219468	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	19,081	3,951,556	3,970,637	0.349284	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	3,732,312	2,539,493	6,271,805	0.234398	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,027,657	8,529,198	9,556,855	0.198264	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,088,223	1,697,381	2,785,604	0.342780	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	183,481	617,325	800,806	0.611528	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	5,095,170	9,396,619	14,491,789	0.047856	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	175,580	6,243,242	6,418,822	0.091648	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,514,860	9,967,111	15,481,971	0.185825	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,231,370	4,779,579	10,010,949	0.216586	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,612,591	62,071,526	74,684,117	0.161095	0.000000	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0.000000	0.000000	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	210	1,258,263	1,258,473	0.749435	0.000000	76.03
76.04	03952	PAIN CLINIC	19,801	1,853,244	1,873,045	0.141349	0.000000	76.04
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	5,347,670	29,080,300	34,427,970	0.154108	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	752,241	1,327,182	2,079,423	0.678359	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	96,304,894	301,290,509	397,595,403			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	96,304,894	301,290,509	397,595,403			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0052

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/20/2020 8:51 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000			62.00
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
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
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
76.00	03950	THERAPEUTIC ACTIVITIES	0.000000			76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000			76.03
76.04	03952	PAIN CLINIC	0.000000			76.04
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: 14-0052

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part I
Date/Time Prepared:
2/20/2020 8:51 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	758,977	0	758,977	9,564	79.36	30.00
31.00	INTENSIVE CARE UNIT	342,972		342,972	1,115	307.60	31.00
43.00	NURSERY	37		37	0	0.00	43.00
200.00	Total (lines 30 through 199)	1,101,986		1,101,986	10,679		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,783	300,219				30.00
31.00	INTENSIVE CARE UNIT	420	129,192				31.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	4,203	429,411				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0052	Period: From 10/01/2018 To 09/30/2019	Worksheet D Part II Date/Time Prepared: 2/20/2020 8:51 am			
				Title XVIII		Hospital		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	973,395	49,562,819	0.019640	3,941,312	77,407	50.00	
51.00	05100	RECOVERY ROOM	43,716	6,676,957	0.006547	688,460	4,507	51.00	
53.00	05300	ANESTHESIOLOGY	27,417	4,779,657	0.005736	543,522	3,118	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	403,541	35,076,922	0.011504	2,142,548	24,648	54.00	
57.00	05700	CT SCAN	36,044	45,311,915	0.000795	3,977,300	3,162	57.00	
58.00	05800	MRI	13,147	6,704,040	0.001961	564,626	1,107	58.00	
59.00	05900	CARDIAC CATHETERIZATION	51,198	8,250,797	0.006205	1,459,980	9,059	59.00	
60.00	06000	LABORATORY	339,241	44,635,118	0.007600	5,918,786	44,983	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	13,226	1,279,276	0.010339	312,781	3,234	62.00	
64.00	06400	INTRAVENOUS THERAPY	74,082	3,970,637	0.018657	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	64,246	6,271,805	0.010244	1,611,806	16,511	65.00	
66.00	06600	PHYSICAL THERAPY	114,429	9,556,855	0.011973	486,698	5,827	66.00	
67.00	06700	OCCUPATIONAL THERAPY	80,284	2,785,604	0.028821	546,331	15,746	67.00	
68.00	06800	SPEECH PATHOLOGY	40,339	800,806	0.050373	106,549	5,367	68.00	
69.00	06900	ELECTROCARDIOLOGY	92,808	14,491,789	0.006404	2,520,346	16,140	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	40,412	6,418,822	0.006296	75,923	478	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	89,732	15,481,971	0.005796	2,194,463	12,719	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	65,162	10,010,949	0.006509	2,314,125	15,063	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	271,827	74,684,117	0.003640	5,182,926	18,866	73.00	
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0.000000	0	0	76.00	
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	34,097	1,258,473	0.027094	210	6	76.03	
76.04	03952	PAIN CLINIC	10,634	1,873,045	0.005677	8,531	48	76.04	
	OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	261,596	34,427,970	0.007598	2,891,880	21,973	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	107,054	2,079,423	0.051483	409,829	21,099	92.00	
200.00		Total (lines 50 through 199)	3,247,627	386,389,767		37,898,932	321,068	200.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS						Provider CCN: 14-0052		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part III Date/Time Prepared: 2/20/2020 8:51 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		30.00	
31.00	03100	INTENSIVE CARE UNIT		0	0		0		0		31.00	
43.00	04300	NURSERY		0	0		0		0		43.00	
200.00		Total (lines 30 through 199)		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		9,564		0.00	3,783	30.00	
31.00	03100	INTENSIVE CARE UNIT			0		1,115		0.00	420	31.00	
43.00	04300	NURSERY			0		0		0.00	0	43.00	
200.00		Total (lines 30 through 199)			0		10,679			4,203	200.00	
Cost Center Description						Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
						9.00						
INPATIENT ROUTINE SERVICE COST CENTERS												
30.00	03000	ADULTS & PEDIATRICS		0							30.00	
31.00	03100	INTENSIVE CARE UNIT		0							31.00	
43.00	04300	NURSERY		0							43.00	
200.00		Total (lines 30 through 199)		0							200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0052		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/20/2020 8:51 am	
			Title XVIII		Hospital		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	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
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
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
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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	0	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.03
76.04	03952	PAIN CLINIC	0	0	0	0	0	76.04
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	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0052

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/20/2020 8:51 am

				Title XVIII		Hospital	PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	49,562,819	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	6,676,957	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,779,657	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	35,076,922	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	45,311,915	0.000000	57.00
58.00	05800	MRI	0	0	0	6,704,040	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	8,250,797	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	44,635,118	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,279,276	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	3,970,637	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,271,805	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	9,556,855	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,785,604	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	800,806	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,491,789	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	6,418,822	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	15,481,971	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,010,949	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	74,684,117	0.000000	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0.000000	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	1,258,473	0.000000	76.03
76.04	03952	PAIN CLINIC	0	0	0	1,873,045	0.000000	76.04
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	34,427,970	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,079,423	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	386,389,767		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0052

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/20/2020 8:51 am

				Title XVIII		Hospital	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	3,941,312	0	9,192,918	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	688,460	0	1,269,097	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	543,522	0	868,834	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,142,548	0	9,077,508	0	54.00
57.00	05700	CT SCAN	0.000000	3,977,300	0	8,753,241	0	57.00
58.00	05800	MRI	0.000000	564,626	0	1,193,490	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	1,459,980	0	1,304,160	0	59.00
60.00	06000	LABORATORY	0.000000	5,918,786	0	4,553,280	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	312,781	0	151,423	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	1,075,079	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,611,806	0	693,871	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	486,698	0	14,994	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	546,331	0	11,591	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	106,549	0	1,944	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,520,346	0	2,441,573	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	75,923	0	1,223,181	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	2,194,463	0	2,484,120	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	2,314,125	0	1,534,990	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	5,182,926	0	21,322,277	0	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0.000000	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	210	0	256,992	0	76.03
76.04	03952	PAIN CLINIC	0.000000	8,531	0	386,042	0	76.04
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.000000	2,891,880	0	5,529,379	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	409,829	0	322,022	0	92.00
200.00		Total (lines 50 through 199)		37,898,932	0	73,662,006	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0052

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part V
Date/Time Prepared:
2/20/2020 8:51 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	0.165157	9,192,918	0	0	1,518,275	50.00
51.00	05100	RECOVERY ROOM	0.119539	1,269,097	0	0	151,707	51.00
53.00	05300	ANESTHESIOLOGY	0.028799	868,834	0	0	25,022	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161728	9,077,508	0	0	1,468,087	54.00
57.00	05700	CT SCAN	0.021156	8,753,241	0	0	185,184	57.00
58.00	05800	MRI	0.049759	1,193,490	0	0	59,387	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.102735	1,304,160	0	0	133,983	59.00
60.00	06000	LABORATORY	0.140310	4,553,280	1,700	0	638,871	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.219468	151,423	0	0	33,233	62.00
64.00	06400	INTRAVENOUS THERAPY	0.349284	1,075,079	0	0	375,508	64.00
65.00	06500	RESPIRATORY THERAPY	0.234398	693,871	0	0	162,642	65.00
66.00	06600	PHYSICAL THERAPY	0.198264	14,994	0	0	2,973	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.342780	11,591	0	0	3,973	67.00
68.00	06800	SPEECH PATHOLOGY	0.611528	1,944	0	0	1,189	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047856	2,441,573	0	0	116,844	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.091648	1,223,181	0	0	112,102	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.185825	2,484,120	0	0	461,612	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.216586	1,534,990	0	0	332,457	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.161095	21,322,277	0	108,159	3,434,912	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0.000000	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.749435	256,992	0	0	192,599	76.03
76.04	03952	PAIN CLINIC	0.141349	386,042	0	0	54,567	76.04
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.154108	5,529,379	0	0	852,122	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.678359	322,022	0	0	218,447	92.00
200.00		Subtotal (see instructions)		73,662,006	1,700	108,159	10,535,696	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0		201.00
		Only Charges						
202.00		Net Charges (line 200 - line 201)		73,662,006	1,700	108,159	10,535,696	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0052

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part V
Date/Time Prepared:
2/20/2020 8:51 am

			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	239	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
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
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
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	17,424		73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0		76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.03
76.04	03952	PAIN CLINIC	0	0		76.04
	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)	239	17,424		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	239	17,424		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0052	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/20/2020 8:51 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)		9,564	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		9,564	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)		8,215	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)		3,783	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)		10,000,663	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)		10,000,663	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)		10,000,663	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)		1,045.66	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,955,732	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)		3,955,732	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0052

Period:
From 10/01/2018
To 09/30/2019

Worksheet D-1

Date/Time Prepared:

2/20/2020 8:51 am

			Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	3,933,991	1,115	3,528.24	420	1,481,861	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					5,580,931	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					11,018,524	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					429,411	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					321,068	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					750,479	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					10,268,045	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,349	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,045.66	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,410,595	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0052

Period:
From 10/01/2018
To 09/30/2019

Worksheet D-1

Date/Time Prepared:
2/20/2020 8:51 am

Cost Center Description		Title XVIII		Hospital	PPS	
		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	758,977	10,000,663	0.075893	1,410,595	107,054
91.00	Nursing School cost	0	10,000,663	0.000000	1,410,595	0
92.00	Allied health cost	0	10,000,663	0.000000	1,410,595	0
93.00	All other Medical Education	0	10,000,663	0.000000	1,410,595	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0052	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/20/2020 8:51 am
Cost Center Description			Title XVIII	Hospital	PPS
			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		3,581,922	30.00
31.00	03100	INTENSIVE CARE UNIT		1,075,197	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.165157	3,941,312	50.00
51.00	05100	RECOVERY ROOM	0.119539	688,460	51.00
53.00	05300	ANESTHESIOLOGY	0.028799	543,522	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161728	2,142,548	54.00
57.00	05700	CT SCAN	0.021156	3,977,300	57.00
58.00	05800	MRI	0.049759	564,626	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.102735	1,459,980	59.00
60.00	06000	LABORATORY	0.140466	5,918,786	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.219468	312,781	62.00
64.00	06400	INTRAVENOUS THERAPY	0.349284	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.234398	1,611,806	65.00
66.00	06600	PHYSICAL THERAPY	0.198264	486,698	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.342780	546,331	67.00
68.00	06800	SPEECH PATHOLOGY	0.611528	106,549	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047856	2,520,346	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.091648	75,923	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.185825	2,194,463	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.216586	2,314,125	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.161095	5,182,926	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0.000000	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.749435	210	76.03
76.04	03952	PAIN CLINIC	0.141349	8,531	76.04
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.154108	2,891,880	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.678359	409,829	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		37,898,932	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)		37,898,932	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0052		Period: From 10/01/2018 To 09/30/2019		Worksheet D-3 Date/Time Prepared: 2/20/2020 8:51 am	
			Title V		Hospital			
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
43.00	04300	NURSERY				0		43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000			0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000			0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000			0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			0	0	54.00
57.00	05700	CT SCAN	0.000000			0	0	57.00
58.00	05800	MRI	0.000000			0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			0	0	59.00
60.00	06000	LABORATORY	0.000000			0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000			0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000			0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000			0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000			0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			0	0	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0.000000			0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000			0	0	76.03
76.04	03952	PAIN CLINIC	0.000000			0	0	76.04
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.000000			0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)				0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)				0	0	201.00
202.00		Net charges (line 200 minus line 201)				0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0052

Period:
From 10/01/2018
To 09/30/2019Worksheet E
Part A
Date/Time Prepared:
2/20/2020 8:51 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)			0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			8,809,455	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)			0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)			0	1.04
2.00	Outlier payments for discharges. (see instructions)				2.00
2.01	Outlier reconciliation amount			0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)			0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)			0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			29,978	2.04
3.00	Managed Care Simulated Payments			0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			45.30	4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)			0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)			0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)			0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00	11.00
12.00	Current year allowable FTE (see instructions)			0.00	12.00
13.00	Total allowable FTE count for the prior year.			0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.			0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.00	15.00
16.00	Adjustment for residents in initial years of the program			0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00	17.00
18.00	Adjusted rolling average FTE count			0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	21.00
22.00	IME payment adjustment (see instructions)			0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).			0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)			0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)			0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)			0	28.01
29.00	Total IME payment (sum of lines 22 and 28)			0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			6.97	30.00
31.00	Percentage of Medicaid patient days (see instructions)			22.12	31.00
32.00	Sum of lines 30 and 31			29.09	32.00
33.00	Allowable disproportionate share percentage (see instructions)			12.00	33.00
34.00	Disproportionate share adjustment (see instructions)			264,284	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0052	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part A Date/Time Prepared: 2/20/2020 8:51 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	8,272,872,447	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000114787	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	949,615	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	949,615	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	949,615		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)	10,053,332		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)		10,053,332	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		716,561	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		10,769,893	59.00
60.00	Primary payer payments		3,630	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		10,766,263	61.00
62.00	Deductibles billed to program beneficiaries		1,123,228	62.00
63.00	Coinsurance billed to program beneficiaries		10,182	63.00
64.00	Allowable bad debts (see instructions)		361,458	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		234,948	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		345,353	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		9,867,801	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		36,792	70.93
70.94	HRR adjustment amount (see instructions)		-141,832	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0052

Period:
From 10/01/2018
To 09/30/2019Worksheet E
Part A
Date/Time Prepared:
2/20/2020 8:51 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)		0	0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		9,762,761		71.00
71.01	Sequestration adjustment (see instructions)		195,255		71.01
71.02	Demonstration payment adjustment amount after sequestration		0		71.02
72.00	Interim payments		9,538,294		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		29,212		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		284,721		75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000		101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000		103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0052	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part B Date/Time Prepared: 2/20/2020 8:51 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		17,663	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		10,535,696	2.00
3.00	OPPS payments		8,914,957	3.00
4.00	Outlier payment (see instructions)		2,905	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)		17,663	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		109,859	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)		109,859	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)		109,859	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		92,196	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)		17,663	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)		8,917,862	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)		1,785,120	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)		7,150,405	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)		7,150,405	30.00
31.00	Primary payer payments		1,706	31.00
32.00	Subtotal (line 30 minus line 31)		7,148,699	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)		398,850	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		259,253	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		372,802	36.00
37.00	Subtotal (see instructions)		7,407,952	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENT FROM THE PS&R		-137	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)		7,407,815	40.00
40.01	Sequestration adjustment (see instructions)		148,156	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		7,312,180	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-52,521	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: 14-0052

Period:
From 10/01/2018
To 09/30/2019Worksheet E-1
Part I
Date/Time Prepared:
2/20/2020 8:51 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		9,490,707		7,290,215	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	04/24/2019	47,587	04/24/2019	21,965	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		47,587		21,965	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)		9,538,294		7,312,180	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		29,212		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		52,521	6.02
7.00	Total Medicare program liability (see instructions)		9,567,506		7,259,659	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: 14-0052

Period:
From 10/01/2018
To 09/30/2019Worksheet E-1
Part II
Date/Time Prepared:
2/20/2020 8:51 am

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

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

Provider CCN: 14-0052

Period:
From 10/01/2018
To 09/30/2019

Worksheet G

Date/Time Prepared:
2/20/2020 8:51 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	1,699,827	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	51,563,333	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-39,833,894	0	0	0	6.00
7.00	Inventory	2,720,991	0	0	0	7.00
8.00	Prepaid expenses	109,012	0	0	0	8.00
9.00	Other current assets	82,886	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)	16,342,155	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,080,000	0	0	0	12.00
13.00	Land improvements	6,842,123	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	56,539,703	0	0	0	15.00
16.00	Accumulated depreciation	-43,473,028	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	-6,404,204	0	0	0	18.00
19.00	Fixed equipment	29,365,837	0	0	0	19.00
20.00	Accumulated depreciation	-22,088,669	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	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	13,243,257	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	35,105,019	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	3,441,385	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	6,575,414	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	10,016,799	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	61,463,973	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	3,263,953	0	0	0	37.00
38.00	Salaries, wages, and fees payable	327,979	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	76,848,962	0	0	0	40.00
41.00	Deferred income	159,238	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	5,862	0	0	0	43.00
44.00	Other current liabilities	5,436,832	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	86,042,826	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	44,764,570	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	44,764,570	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	130,807,396	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-69,343,423	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)	-69,343,423	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	61,463,973	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0052

Period:
From 10/01/2018
To 09/30/2019

Worksheet G-1

Date/Time Prepared:
2/20/2020 8:51 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		-39,462,394		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-8,723,899				2.00
3.00	Total (sum of line 1 and line 2)		-48,186,293		0		3.00
4.00	INCREASE IN RESTRICTED ASSETS	1,564,306		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		1,564,306		0		10.00
11.00	Subtotal (line 3 plus line 10)		-46,621,987		0		11.00
12.00	PENSION ADJUSTMENT	12,441,669		0		0	12.00
13.00	OSFMG EQUITY TRANSFER	127,637		0		0	13.00
14.00	OTHER DIFFERENCE	145,314		0		0	14.00
15.00	EQUITY TRANSFER	10,006,816		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)		22,721,436		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-69,343,423		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	INCREASE IN RESTRICTED ASSETS		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	PENSION ADJUSTMENT		0				12.00
13.00	OSFMG EQUITY TRANSFER		0				13.00
14.00	OTHER DIFFERENCE		0				14.00
15.00	EQUITY TRANSFER		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: 14-0052

Period:
From 10/01/2018
To 09/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
2/20/2020 8:51 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	7,694,090		7,694,090	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	7,694,090		7,694,090	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,512,497		3,512,497	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	3,512,497		3,512,497	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	11,206,587		11,206,587	17.00
18.00	Ancillary services	85,079,246	298,179,002	383,258,248	18.00
19.00	Outpatient services	20,011	3,111,507	3,131,518	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	PROFESSIONAL FEES	11,361	945,820	957,181	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	96,317,205	302,236,329	398,553,534	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		81,331,465		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		81,331,465		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0052

Period:
From 10/01/2018
To 09/30/2019

Worksheet G-3

Date/Time Prepared:
2/20/2020 8:51 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	398,553,534	1.00
2.00	Less contractual allowances and discounts on patients' accounts	327,306,437	2.00
3.00	Net patient revenues (line 1 minus line 2)	71,247,097	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	81,331,465	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-10,084,368	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	-47,896	6.00
7.00	Income from investments	27,727	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	368,689	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	150,842	17.00
18.00	Revenue from sale of medical records and abstracts	579	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	122,072	22.00
23.00	Governmental appropriations	0	23.00
24.00	LOSS ON ALE OF ASSET AND OTHER	-136,726	24.00
24.01	BLUE CROSS QUALITY/RISK RESERVE	625,538	24.01
24.02	FINANCE CHARGE	138,843	24.02
24.03	OTHER MGMT FEE	110,801	24.03
25.00	Total other income (sum of lines 6-24)	1,360,469	25.00
26.00	Total (line 5 plus line 25)	-8,723,899	26.00
27.00	STATE AND FEDERAL TAXES	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)	-8,723,899	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0052	Period: From 10/01/2018 To 09/30/2019	Worksheet L Parts I-III Date/Time Prepared: 2/20/2020 8:51 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		711,779	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		4,782	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)		25.56	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		716,561	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