

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: 14-0083	Period: From 07/01/2018 To 06/30/2019	Worksheet S Parts I-III Date/Time Prepared: 11/21/2019 8:40 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 11/21/2019	Time: 8:40 am
	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 LORETTO HOSPITAL (14-0083) for the cost reporting period beginning 07/01/2018 and ending 06/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	431,407	-13,102	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	431,407	-13,102	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: 14-0083		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/21/2019 8:40 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 645 SOUTH CENTRAL AVENUE			PO Box:				1.00	
2.00	City: CHICAGO			State: IL		Zip Code: 60646		County: COOK	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			LORETTO HOSPITAL	140083	16974	1	07/01/1966	N
4.00	Subprovider - IPF							P	0
5.00	Subprovider - IRF								
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								
17.10	Hospital-Based (CORF) I								
17.20	Hospital-Based (OPT) I								
17.30	Hospital-Based (OOT) I								
17.40	Hospital-Based (OSP) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2018	06/30/2019	
21.00	Type of Control (see instructions)						2		
							1.00	2.00	
							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		
22.01	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		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N		

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Provider CCN: 14-0083		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/21/2019 8:40 am	
			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	
			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	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.								
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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

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			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	N	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	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	N	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	N	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	N	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	N	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				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.	2			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1,601,798	0	0	
		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.	N			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N			140.00

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1.00		2.00		3.00						
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.										
141.00	Name:	Contractor's Name:		Contractor's Number:				141.00		
142.00	Street:	PO Box:						142.00		
143.00	City:	State:		Zip Code:				143.00		
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00	
								1.00	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		N		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N				146.00	
								1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00	
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital	N		N		N		N		155.00
156.00	Subprovider - IPF	N		N		N		N		156.00
157.00	Subprovider - IRF	N		N		N		N		157.00
158.00	SUBPROVIDER									158.00
159.00	SNF	N		N		N		N		159.00
160.00	HOME HEALTH AGENCY	N		N		N		N		160.00
161.00	CMHC			N		N		N		161.00
161.10	CORF			N		N		N		161.10
161.20	OUTPATIENT PHYSICAL THERAPY			N		N		N		161.20
161.30	OUTPATIENT OCCUPATIONAL THERAPY			N		N		N		161.30
161.40	OUTPATIENT SPEECH PATHOLOGY			N		N		N		161.40
								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.							N	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00	
						Beginning	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)								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: 14-0083	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 11/21/2019 8:40 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N		14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N		15.00
			Part A		Part B
			Y/N	Date	Y/N
			1.00	2.00	3.00
			4.00		
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/17/2019	Y	10/17/2019
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
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: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part II
Date/Time Prepared:
11/21/2019 8:40 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KENNETH		MCGHEE	41.00
42.00	Enter the employer/company name of the cost report preparer.	LORETTO HOSPITAL			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	773-854-5008		KENNETH.MCGHEE@LORETTOHOSPITAL.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part II
Date/Time Prepared:
11/21/2019 8:40 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.	VP CTO	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: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/21/2019 8:40 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	110	40,150	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)		110	40,150	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,380	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 DETOXIFICATION INTENSIVE CARE UNIT	35.00	0	0	0.00	0	12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		122	44,530	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
25.10 CMHC - CORF	99.10				0	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.40
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)		122				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: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/21/2019 8:40 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)	3,202	2,374	16,663			1.00
2.00	HMO and other (see instructions)	1,411	9,271				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)	3,202	2,374	16,663			7.00
8.00	INTENSIVE CARE UNIT	386	90	1,424			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	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0			12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	3,588	2,464	18,087	2.00	514.34	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)			6			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00	25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00	25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00	25.40
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)				2.00	514.34	27.00
28.00	Observation Bed Days		0	1,187			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: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/21/2019 8:40 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	630	555	3,954	1.00
2.00 HMO and other (see instructions)			286	2,269		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 DETOXIFICATION INTENSIVE CARE UNIT						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	630	555	3,954	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
25.10 CMHC - CORF	0.00					25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0.00					25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00					25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00					25.40
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: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part II
Date/Time Prepared:
11/21/2019 8:40 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	11/21/2019 8:40 am 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	35,579,690	0	35,579,690	1,069,825.35	33.26	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	90,132	0	90,132	4,160.00	21.67	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,008,021	0	1,008,021	7,085.41	142.27	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		6,049,163	0	6,049,163			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		176,839	0	176,839			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		15,812	0	15,812			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	351,342	0	351,342	10,881.37	32.29	26.00
27.00	Administrative & General	5.00	8,467,810	0	8,467,810	204,018.32	41.51	27.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part II
Date/Time Prepared:
11/21/2019 8:40 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.)		72,510	0	72,510	332.40	218.14	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,417,960	0	1,417,960	39,837.77	35.59	30.00
31.00	Laundry & Linen Service	8.00	4,740	0	4,740	373.32	12.70	31.00
32.00	Housekeeping	9.00	958,998	0	958,998	56,369.15	17.01	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	768,652	-191,261	577,391	35,536.15	16.25	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	191,261	191,261	11,771.40	16.25	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,705,453	0	1,705,453	45,006.02	37.89	38.00
39.00	Central Services and Supply	14.00	243,323	0	243,323	12,029.02	20.23	39.00
40.00	Pharmacy	15.00	724,361	0	724,361	17,865.54	40.55	40.00
41.00	Medical Records & Medical Records Library	16.00	578,315	0	578,315	22,348.68	25.88	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: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part III
Date/Time Prepared:
11/21/2019 8:40 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)	35,562,068	0	35,562,068	1,065,997.75	33.36	1.00
2.00	Excluded area salaries (see instructions)	1,008,021	0	1,008,021	7,085.41	142.27	2.00
3.00	Subtotal salaries (line 1 minus line 2)	34,554,047	0	34,554,047	1,058,912.34	32.63	3.00
4.00	Subtotal other wages & related costs (see inst.)	0	0	0	0.00	0.00	4.00
5.00	Subtotal wage-related costs (see inst.)	6,049,163	0	6,049,163	0.00	17.51	5.00
6.00	Total (sum of lines 3 thru 5)	40,603,210	0	40,603,210	1,058,912.34	38.34	6.00
7.00	Total overhead cost (see instructions)	15,293,464	0	15,293,464	456,369.14	33.51	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part IV
Date/Time Prepared:
11/21/2019 8:40 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	367,510	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	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)	3,179,005	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	178,311	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)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	0	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	2,516,988	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	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	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	6,241,814	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COST	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part V
Date/Time Prepared:
11/21/2019 8:40 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	0	6,241,814	1.00
2.00	Hospital	0	6,241,814	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
16.10	Hospital-Based-CMHC 10	0	0	16.10
16.20	Hospital-Based-CMHC 20	0	0	16.20
16.30	Hospital-Based-CMHC 30	0	0	16.30
16.40	Hospital-Based-CMHC 40	0	0	16.40
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0083

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

Worksheet S-7

Date/Time Prepared:
11/21/2019 8:40 am

		1.00	2.00	3.00	4.00
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.				1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.				2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	0 3.00
4.00		RUL	0	0	0 4.00
5.00		RVX	0	0	0 5.00
6.00		RVL	0	0	0 6.00
7.00		RHX	0	0	0 7.00
8.00		RHL	0	0	0 8.00
9.00		RMX	0	0	0 9.00
10.00		RML	0	0	0 10.00
11.00		RLX	0	0	0 11.00
12.00		RUC	0	0	0 12.00
13.00		RUB	0	0	0 13.00
14.00		RUA	0	0	0 14.00
15.00		RVC	0	0	0 15.00
16.00		RVB	0	0	0 16.00
17.00		RVA	0	0	0 17.00
18.00		RHC	0	0	0 18.00
19.00		RHB	0	0	0 19.00
20.00		RHA	0	0	0 20.00
21.00		RMC	0	0	0 21.00
22.00		RMB	0	0	0 22.00
23.00		RMA	0	0	0 23.00
24.00		RLB	0	0	0 24.00
25.00		RLA	0	0	0 25.00
26.00		ES3	0	0	0 26.00
27.00		ES2	0	0	0 27.00
28.00		ES1	0	0	0 28.00
29.00		HE2	0	0	0 29.00
30.00		HE1	0	0	0 30.00
31.00		HD2	0	0	0 31.00
32.00		HD1	0	0	0 32.00
33.00		HC2	0	0	0 33.00
34.00		HC1	0	0	0 34.00
35.00		HB2	0	0	0 35.00
36.00		HB1	0	0	0 36.00
37.00		LE2	0	0	0 37.00
38.00		LE1	0	0	0 38.00
39.00		LD2	0	0	0 39.00
40.00		LD1	0	0	0 40.00
41.00		LC2	0	0	0 41.00
42.00		LC1	0	0	0 42.00
43.00		LB2	0	0	0 43.00
44.00		LB1	0	0	0 44.00
45.00		CE2	0	0	0 45.00
46.00		CE1	0	0	0 46.00
47.00		CD2	0	0	0 47.00
48.00		CD1	0	0	0 48.00
49.00		CC2	0	0	0 49.00
50.00		CC1	0	0	0 50.00
51.00		CB2	0	0	0 51.00
52.00		CB1	0	0	0 52.00
53.00		CA2	0	0	0 53.00
54.00		CA1	0	0	0 54.00
55.00		SE3	0	0	0 55.00
56.00		SE2	0	0	0 56.00
57.00		SE1	0	0	0 57.00
58.00		SSC	0	0	0 58.00
59.00		SSB	0	0	0 59.00
60.00		SSA	0	0	0 60.00
61.00		IB2	0	0	0 61.00
62.00		IB1	0	0	0 62.00
63.00		IA2	0	0	0 63.00
64.00		IA1	0	0	0 64.00
65.00		BB2	0	0	0 65.00
66.00		BB1	0	0	0 66.00
67.00		BA2	0	0	0 67.00
68.00		BA1	0	0	0 68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0083

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

Worksheet S-7

Date/Time Prepared:
11/21/2019 8:40 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	0	0	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
SNF SERVICES						
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).					201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		0	0.00		202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		0			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0083

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

Worksheet S-10

Date/Time Prepared:
11/21/2019 8:40 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)		0.644342	1.00
	Medicaid (see instructions for each line)			
2.00	Net revenue from Medicaid		7,645,259	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		3,764,560	5.00
6.00	Medicaid charges		26,794,141	6.00
7.00	Medicaid cost (line 1 times line 6)		17,264,590	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)		5,854,771	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)		5,854,771	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)	2,068,649	0	2,068,649
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,332,917	0	1,332,917
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	1,332,917	0	1,332,917
				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)		1,882,763	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		383,964	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		590,714	27.01
28.00	Non-Medicare bad debt expense (see instructions)		1,292,049	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,039,271	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		2,372,188	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		8,226,959	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0083

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

Worksheet A

Date/Time Prepared:
11/21/2019 8:40 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati 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		2,960,022	2,960,022	-544,938	2,415,084	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	651,832	651,832	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	351,342	4,229,673	4,581,015	0	4,581,015	4.00
5.01	01160	COMMUNICATIONS	171,182	216,576	387,758	0	387,758	5.01
5.04	00570	ADMITTING	192,043	21,906	213,949	0	213,949	5.04
5.05	00580	BUSINESS OFFICE	791,288	1,812,855	2,604,143	0	2,604,143	5.05
5.06	00590	OTHER ADMINISTRATIVE	7,313,297	10,561,420	17,874,717	-106,894	17,767,823	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,417,960	2,075,657	3,493,617	0	3,493,617	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,740	136,426	141,166	0	141,166	8.00
9.00	00900	HOUSEKEEPING	958,998	705,299	1,664,297	0	1,664,297	9.00
10.00	01000	DIETARY	768,652	1,273,302	2,041,954	-508,093	1,533,861	10.00
11.00	01100	CAFETERIA	0	599	599	508,093	508,692	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,705,453	200,097	1,905,550	0	1,905,550	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	243,323	146,984	390,307	-14,517	375,790	14.00
15.00	01500	PHARMACY	724,361	1,231,385	1,955,746	-654,339	1,301,407	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	578,315	176,170	754,485	0	754,485	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	90,132	14,911	105,043	0	105,043	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,835,513	2,399,265	11,234,778	0	11,234,778	30.00
31.00	03100	INTENSIVE CARE UNIT	1,539,226	682,791	2,222,017	0	2,222,017	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0	35.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	541,796	600,445	1,142,241	-164,414	977,827	50.00
53.00	05300	ANESTHESIOLOGY	0	400,000	400,000	0	400,000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	913,783	1,223,590	2,137,373	0	2,137,373	54.00
57.00	05700	CT SCAN	259,592	126,616	386,208	0	386,208	57.00
60.00	06000	LABORATORY	996,360	1,320,656	2,317,016	0	2,317,016	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	646,580	96,810	743,390	-18,779	724,611	65.00
66.00	06600	PHYSICAL THERAPY	339,608	66,311	405,919	-6,170	399,749	66.00
69.00	06900	ELECTROCARDIOLOGY	125,578	58,791	184,369	0	184,369	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	21,771	1,916	23,687	0	23,687	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	218,989	218,989	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	654,233	654,233	73.00
74.00	07400	RENAL DIALYSIS	0	87,870	87,870	0	87,870	74.00
75.01	07501	HYPERBARIC CHAMBER	0	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	35,779	10,013	45,792	0	45,792	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,016,137	1,095,335	2,111,472	-15,003	2,096,469	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	0	312	312	0	312	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	0	90.03
90.04	09004	CLINIC #4	0	0	0	0	0	90.04
90.05	09005	WOUND CARE	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	3,988,860	1,030,833	5,019,693	0	5,019,693	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,571,669	34,964,836	69,536,505	0	69,536,505	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	PUBLIC RELATIONS	254,259	111,073	365,332	0	365,332	194.00
194.01	07952	RESEARCH	64,224	14,459	78,683	0	78,683	194.01
194.02	07953	OPMH	689,538	174,454	863,992	0	863,992	194.02
194.10	07951	AUSTIN PRIDE	0	0	0	0	0	194.10

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0083

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

Worksheet A

Date/Time Prepared:
11/21/2019 8:40 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
200.00	TOTAL (SUM OF LINES 118 through 199)	35,579,690	35,264,822	70,844,512	0	70,844,512	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0083

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

Worksheet A

Date/Time Prepared:
11/21/2019 8:40 am

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-31,933	2,383,151	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	651,832	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,581,015	4.00
5.01	01160	COMMUNICATIONS	0	387,758	5.01
5.04	00570	ADMITTING	0	213,949	5.04
5.05	00580	BUSINESS OFFICE	0	2,604,143	5.05
5.06	00590	OTHER ADMINISTRATIVE	-4,732,807	13,035,016	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	3,493,617	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	141,166	8.00
9.00	00900	HOUSEKEEPING	0	1,664,297	9.00
10.00	01000	DIETARY	0	1,533,861	10.00
11.00	01100	CAFETERIA	-156,394	352,298	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,905,550	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	375,790	14.00
15.00	01500	PHARMACY	0	1,301,407	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	754,485	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	105,043	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,203,782	10,030,996	30.00
31.00	03100	INTENSIVE CARE UNIT	-215,159	2,006,858	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	35.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-104,858	872,969	50.00
53.00	05300	ANESTHESIOLOGY	-400,000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-228,796	1,908,577	54.00
57.00	05700	CT SCAN	0	386,208	57.00
60.00	06000	LABORATORY	0	2,317,016	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	724,611	65.00
66.00	06600	PHYSICAL THERAPY	0	399,749	66.00
69.00	06900	ELECTROCARDIOLOGY	0	184,369	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	23,687	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	218,989	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	654,233	73.00
74.00	07400	RENAL DIALYSIS	0	87,870	74.00
75.01	07501	HYPERBARIC CHAMBER	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	0	45,792	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-467,474	1,628,995	90.00
90.01	09001	CICERO CLINIC	0	0	90.01
90.02	09002	YMCA CLINIC	0	312	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	90.03
90.04	09004	CLINIC #4	0	0	90.04
90.05	09005	WOUND CARE	0	0	90.05
91.00	09100	EMERGENCY	-234,938	4,784,755	91.00
91.01	09101	GOLDEN LIFE	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-7,776,141	61,760,364	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07950	PUBLIC RELATIONS	0	365,332	194.00
194.01	07952	RESEARCH	0	78,683	194.01
194.02	07953	OPMH	0	863,992	194.02
194.10	07951	AUSTIN PRIDE	0	0	194.10
200.00		TOTAL (SUM OF LINES 118 through 199)	-7,776,141	63,068,371	200.00

RECLASSIFICATIONS

Provider CCN: 14-0083

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

Worksheet A-6

Date/Time Prepared:
11/21/2019 8:40 am

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - DRUGS SOLD					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	654,233	1.00
	TOTALS		0	654,233	
B - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	191,261	316,832	1.00
	TOTALS		191,261	316,832	
D - DEPR EXP					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	594,677	1.00
	TOTALS		0	594,677	
E - SUPPLIES CHARGED					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	218,989	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	TOTALS		0	218,989	
F - CAPITAL INSURANCE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	49,739	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	57,155	2.00
	TOTALS		0	106,894	
500.00	Grand Total: Increases		191,261	1,891,625	500.00

RECLASSIFICATIONS

Provider CCN: 14-0083

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

Worksheet A-6

Date/Time Prepared:
11/21/2019 8:40 am

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - DRUGS SOLD						
1.00	PHARMACY	15.00	0	654,233	0	1.00
	TOTALS		0	654,233		
B - CAFETERIA RECLASS						
1.00	DIETARY	10.00	191,261	316,832	0	1.00
	TOTALS		191,261	316,832		
D - DEPR EXP						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	594,677	9	1.00
	TOTALS		0	594,677		
E - SUPPLIES CHARGED						
1.00	OPERATING ROOM	50.00	0	164,414	0	1.00
2.00	RESPIRATORY THERAPY	65.00	0	18,779	0	2.00
3.00	CLINIC	90.00	0	15,003	0	3.00
4.00	PHYSICAL THERAPY	66.00	0	6,170	0	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	14,517	0	5.00
6.00	PHARMACY	15.00	0	106	0	6.00
	TOTALS		0	218,989		
F - CAPITAL INSURANCE EXPENSE						
1.00	OTHER ADMINISTRATIVE	5.00	0	106,894	12	1.00
2.00		0.00	0	0	12	2.00
	TOTALS		0	106,894		
500.00	Grand Total: Decreases		191,261	1,891,625		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part I
Date/Time Prepared:
11/21/2019 8:40 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	429,028	0	0	0	0	1.00	
2.00	Land Improvements	52,143	0	0	0	0	2.00	
3.00	Buildings and Fixtures	41,403,449	700,455	0	700,455	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	11,441,700	165,631	0	165,631	0	5.00	
6.00	Movable Equipment	0	0	0	0	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	53,326,320	866,086	0	866,086	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	53,326,320	866,086	0	866,086	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	429,028	0				1.00	
2.00	Land Improvements	52,143	0				2.00	
3.00	Buildings and Fixtures	42,103,904	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	11,607,331	0				5.00	
6.00	Movable Equipment	0	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	54,192,406	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	54,192,406	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part II
Date/Time Prepared:
11/21/2019 8:40 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,689,672	0	270,350	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,689,672	0	270,350	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	2,960,022				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	2,960,022				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part III
Date/Time Prepared:
11/21/2019 8:40 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	42,585,075	0	42,585,075	0.785813	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11,607,331	0	11,607,331	0.214187	0	2.00
3.00	Total (sum of lines 1-2)	54,192,406	0	54,192,406	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,063,062	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	594,677	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,657,739	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	270,350	49,739	0	0	2,383,151	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	57,155	0	0	651,832	2.00
3.00	Total (sum of lines 1-2)	270,350	106,894	0	0	3,034,983	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0083

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

Worksheet A-8

Date/Time Prepared:
11/21/2019 8:40 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	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,695,953			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	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-153,620	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-2,774	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME	B	-109,587	OTHER ADMINISTRATIVE	5.06	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0083

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

Worksheet A-8

Date/Time Prepared:
11/21/2019 8:40 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	
33.02	TELEPHONE CAPITAL	A	-2,282	CAP REL COSTS-BLDG & FIXT	1.00	9	33.02
35.00	MED REC COPIES	B	-11,237	OPERATING ROOM	50.00	0	35.00
37.00	LOBBYING EXPENSES	A	-6,477	OTHER ADMINISTRATIVE	5.06	0	37.00
38.00	RENTAL INCOME	B	-29,651	CAP REL COSTS-BLDG & FIXT	1.00	9	38.00
39.00	MEDICAID TAX ASSESSMENT	A	-3,764,560	OTHER ADMINISTRATIVE	5.06	0	39.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,776,141				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0083

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

Worksheet A-8-2

Date/Time Prepared:
11/21/2019 8:40 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	1,203,782	1,203,782	0	0	0	1.00
2.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	215,159	215,159	0	0	0	2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	400,000	400,000	0	0	0	3.00
4.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	228,796	228,796	0	0	0	4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	93,621	93,621	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	91.00	AGGREGATE-EMERGENCY	234,938	234,938	0	0	0	7.00
8.00	90.00	AGGREGATE-CLINIC	467,474	467,474	0	0	0	8.00
9.00	5.06	AGGREGATE-OTHER ADMINISTRATIVE	852,183	852,183	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,695,953	3,695,953	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	7.00
8.00	90.00	AGGREGATE-CLINIC	0	0	0	0	0	8.00
9.00	5.06	AGGREGATE-OTHER ADMINISTRATIVE	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	1,203,782		1.00
2.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	215,159		2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	400,000		3.00
4.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	228,796		4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	93,621		5.00
6.00	0.00		0	0	0	0		6.00
7.00	91.00	AGGREGATE-EMERGENCY	0	0	0	234,938		7.00
8.00	90.00	AGGREGATE-CLINIC	0	0	0	467,474		8.00
9.00	5.06	AGGREGATE-OTHER ADMINISTRATIVE	0	0	0	852,183		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	3,695,953		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
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Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,383,151	2,383,151			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	651,832	651,832			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,581,015	14,852	4,062	4,599,929	4.00
5.01	01160	COMMUNICATIONS	387,758	14,407	3,941	22,352	428,458
5.04	00570	ADMITTING	213,949	1,862	509	25,076	4,242
5.05	00580	BUSINESS OFFICE	2,604,143	39,754	10,874	103,322	6,363
5.06	00590	OTHER ADMINISTRATIVE	13,035,016	521,424	142,617	954,934	125,145
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00	00700	OPERATION OF PLANT	3,493,617	249,723	68,304	185,150	6,363
8.00	00800	LAUNDRY & LINEN SERVICE	141,166	30,662	8,387	619	2,121
9.00	00900	HOUSEKEEPING	1,664,297	29,718	8,128	125,221	2,121
10.00	01000	DIETARY	1,533,861	78,848	21,566	75,393	10,605
11.00	01100	CAFETERIA	352,298	34,035	9,309	24,974	6,363
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	1,905,550	8,971	2,454	222,690	21,211
14.00	01400	CENTRAL SERVICES & SUPPLY	375,790	144,098	39,413	31,772	6,363
15.00	01500	PHARMACY	1,301,407	16,350	4,472	94,583	4,242
16.00	01600	MEDICAL RECORDS & LIBRARY	754,485	21,179	5,793	75,513	14,848
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	105,043	5,180	1,417	11,769	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	10,030,996	369,392	101,035	1,153,687	31,816
31.00	03100	INTENSIVE CARE UNIT	2,006,858	85,984	23,518	200,984	10,605
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	872,969	121,516	33,237	70,745	40,301
53.00	05300	ANESTHESIOLOGY	0	4,910	1,343	0	2,121
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,908,577	110,684	30,274	119,317	16,969
57.00	05700	CT SCAN	386,208	7,554	2,066	33,896	0
60.00	06000	LABORATORY	2,317,016	89,357	24,441	130,100	12,726
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	724,611	27,816	7,608	84,427	4,242
66.00	06600	PHYSICAL THERAPY	399,749	42,695	11,678	44,344	14,848
69.00	06900	ELECTROCARDIOLOGY	184,369	7,770	2,125	16,397	6,363
70.00	07000	ELECTROENCEPHALOGRAPHY	23,687	5,275	1,443	2,843	2,121
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	218,989	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	654,233	0	0	0	0
74.00	07400	RENAL DIALYSIS	87,870	0	0	0	0
75.01	07501	HYPERBARIC CHAMBER	0	0	0	0	0
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	0
76.10	03950	PARTIAL HOSPITALIZATION	45,792	92,715	25,359	4,672	4,242
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,628,995	34,075	9,320	132,682	14,848
90.01	09001	CICERO CLINIC	0	0	0	0	0
90.02	09002	YMCA CLINIC	312	0	0	0	0
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	0
90.04	09004	CLINIC #4	0	0	0	0	0
90.05	09005	WOUND CARE	0	0	0	0	0
91.00	09100	EMERGENCY	4,784,755	120,194	32,875	520,845	36,058
91.01	09101	GOLDEN LIFE	0	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	61,760,364	2,331,000	637,568	4,468,307	407,247
NONREIMBURSABLE COST CENTERS							
194.00	07950	PUBLIC RELATIONS	365,332	0	0	33,200	2,121
194.01	07952	RESEARCH	78,683	3,777	1,033	8,386	0

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
194.02	07953	OPMH	863,992	48,374	13,231	90,036	14,848	194.02
194.10	07951	AUSTIN PRIDE	0	0	0	0	4,242	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	63,068,371	2,383,151	651,832	4,599,929	428,458	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			ADMITTING	BUSINESS OFFICE	Subtotal	OTHER ADMINISTRATIVE	MAINTENANCE & REPAIRS	
			5.04	5.05	5A.05	5.06	6.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.04	00570	ADMITTING	245,638					5.04
5.05	00580	BUSINESS OFFICE	0	2,764,456				5.05
5.06	00590	OTHER ADMINISTRATIVE	0	0	14,779,136	14,779,136		5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	4,003,157	1,225,182		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	182,955	55,994		8.00
9.00	00900	HOUSEKEEPING	0	0	1,829,485	559,921		9.00
10.00	01000	DIETARY	0	0	1,720,273	526,496		10.00
11.00	01100	CAFETERIA	0	0	426,979	130,679		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	0	0	2,160,876	661,345		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	597,436	182,848		14.00
15.00	01500	PHARMACY	0	0	1,421,054	434,919		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	871,818	266,823		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0	0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	123,409	37,770		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	105,040	966,403	12,758,369	3,904,775	0	30.00
31.00	03100	INTENSIVE CARE UNIT	17,328	110,241	2,455,518	751,521	0	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0	35.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,761	74,933	1,219,462	373,221	0	50.00
53.00	05300	ANESTHESIOLOGY	513	7,642	16,529	5,059	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,652	95,872	2,286,345	699,745	0	54.00
57.00	05700	CT SCAN	2,933	75,528	508,185	155,532	0	57.00
60.00	06000	LABORATORY	26,923	373,229	2,973,792	910,141	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	19,249	141,841	1,009,794	309,051	0	65.00
66.00	06600	PHYSICAL THERAPY	1,656	22,865	537,835	164,607	0	66.00
69.00	06900	ELECTROCARDIOLOGY	4,944	59,567	281,535	86,165	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	17	226	35,612	10,899	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,414	44,047	265,450	81,242	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,226	266,658	954,117	292,011	0	73.00
74.00	07400	RENAL DIALYSIS	549	3,491	91,910	28,129	0	74.00
75.01	07501	HYPERBARIC CHAMBER	0	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	0	73,879	246,659	75,491	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	174	11,540	1,831,634	560,579	0	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	0	0	312	95	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	0	90.03
90.04	09004	CLINIC #4	0	0	0	0	0	90.04
90.05	09005	WOUND CARE	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	20,259	436,494	5,951,480	1,821,474	0	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	245,638	2,764,456	61,541,116	14,311,714	0	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	PUBLIC RELATIONS	0	0	400,653	122,621	0	194.00
194.01	07952	RESEARCH	0	0	91,879	28,120	0	194.01
194.02	07953	OPMH	0	0	1,030,481	315,383	0	194.02
194.10	07951	AUSTIN PRIDE	0	0	4,242	1,298	0	194.10
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)	245,638	2,764,456	63,068,371	14,779,136	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.04	00570	ADMITTING						5.04
5.05	00580	BUSINESS OFFICE						5.05
5.06	00590	OTHER ADMINISTRATIVE						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	5,228,339					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	104,023	342,972				8.00
9.00	00900	HOUSEKEEPING	100,820	0	2,490,226			9.00
10.00	01000	DIETARY	267,494	0	22,474	2,536,737		10.00
11.00	01100	CAFETERIA	115,464	0	130,940	0	804,062	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	30,434	0	0	0	50,899	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	488,858	0	67,349	0	13,595	14.00
15.00	01500	PHARMACY	55,467	0	29,917	0	20,204	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	71,851	0	22,474	0	25,261	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	17,574	0	0	0	4,704	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,253,174	223,885	651,094	2,445,350	334,539	30.00
31.00	03100	INTENSIVE CARE UNIT	291,704	16,317	119,740	91,387	37,680	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0	35.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	412,248	102,770	190,847	0	13,572	50.00
53.00	05300	ANESTHESIOLOGY	16,658	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	375,499	0	130,940	0	28,978	54.00
57.00	05700	CT SCAN	25,628	0	0	0	7,903	57.00
60.00	06000	LABORATORY	303,145	0	130,940	0	39,115	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	94,367	0	67,349	0	24,179	65.00
66.00	06600	PHYSICAL THERAPY	144,845	0	114,140	0	12,231	66.00
69.00	06900	ELECTROCARDIOLOGY	26,360	0	0	0	5,010	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	17,894	0	0	0	1,082	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.01	07501	HYPERBARIC CHAMBER	0	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	314,541	0	0	0	2,282	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	115,602	0	187,089	0	42,690	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	0	0	0	0	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	0	90.03
90.04	09004	CLINIC #4	0	0	0	0	0	90.04
90.05	09005	WOUND CARE	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	407,763	0	523,909	0	97,965	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0	1,223	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,051,413	342,972	2,389,202	2,536,737	763,112	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	PUBLIC RELATIONS	0	0	0	0	6,774	194.00
194.01	07952	RESEARCH	12,814	0	0	0	1,247	194.01
194.02	07953	OPMH	164,112	0	101,024	0	32,929	194.02
194.10	07951	AUSTIN PRIDE	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,228,339	342,972	2,490,226	2,536,737	804,062	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0083

Period:
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To 06/30/2019Worksheet B
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Cost Center Description			MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			12.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.04	00570	ADMITTING						5.04
5.05	00580	BUSINESS OFFICE						5.05
5.06	00590	OTHER ADMINISTRATIVE						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0					12.00
13.00	01300	NURSING ADMINISTRATION	0	2,903,554				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,350,086			14.00
15.00	01500	PHARMACY	0	0	0	1,961,561		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	1,258,227	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	2,517,819	0	10,853	439,837	30.00
31.00	03100	INTENSIVE CARE UNIT	0	283,676	0	4,686	50,177	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0	35.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	102,059	0	7,400	34,106	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	3,478	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	277	43,637	54.00
57.00	05700	CT SCAN	0	0	0	0	34,377	57.00
60.00	06000	LABORATORY	0	0	0	0	169,877	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	64,559	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	10,407	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	16	27,112	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	103	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,350,086	0	20,048	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,790,175	121,370	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	1,589	74.00
75.01	07501	HYPERBARIC CHAMBER	0	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	0	0	0	0	33,626	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	42,554	5,252	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	0	0	0	854	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	0	90.03
90.04	09004	CLINIC #4	0	0	0	0	0	90.04
90.05	09005	WOUND CARE	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	95,621	198,672	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,903,554	1,350,086	1,952,436	1,258,227	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	PUBLIC RELATIONS	0	0	0	0	0	194.00
194.01	07952	RESEARCH	0	0	0	0	0	194.01
194.02	07953	OPMH	0	0	0	9,125	0	194.02
194.10	07951	AUSTIN PRIDE	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0083

Period:
From 07/01/2018
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Cost Center Description		MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		12.00	13.00	14.00	15.00	16.00	
202.00	TOTAL (sum lines 118 through 201)	0	2,903,554	1,350,086	1,961,561	1,258,227	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0083

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Cost Center Description			INTERNS & RESIDENTS					
			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	SERVICES-SALAR		SERVICES-OTHER
						Y & FRINGES APPRV		PRGM COSTS APPRV
			17.00	19.00	20.00	21.00	22.00	
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	01160	COMMUNICATIONS						5.01
5.04	00570	ADMITTING						5.04
5.05	00580	BUSINESS OFFICE						5.05
5.06	00590	OTHER ADMINISTRATIVE						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	0					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
20.00	02000	NURSING SCHOOL	0		0			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0			183,457		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0				0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0					23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	183,457	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0	35.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.01	07501	HYBERBARIC CHAMBER	0	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	0	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	0	0	0	0	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	0	90.03
90.04	09004	CLINIC #4	0	0	0	0	0	90.04
90.05	09005	WOUND CARE	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	183,457	0	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	PUBLIC RELATIONS	0	0	0	0	0	194.00
194.01	07952	RESEARCH	0	0	0	0	0	194.01
194.02	07953	OPMH	0	0	0	0	0	194.02
194.10	07951	AUSTIN PRIDE	0	0	0	0	0	194.10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0083

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Cost Center Description		SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS		
					SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	
					21.00	22.00	
200.00	Cross Foot Adjustments		0	0	0	0	0 200.00
201.00	Negative Cost Centers	0	0	0	0	0	0 201.00
202.00	TOTAL (sum lines 118 through 201)	0	0	0	183,457	0	0 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.00	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	01160	COMMUNICATIONS					5.01
5.04	00570	ADMITTING					5.04
5.05	00580	BUSINESS OFFICE					5.05
5.06	00590	OTHER ADMINISTRATIVE					5.06
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
20.00	02000	NURSING SCHOOL					20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV					22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	24,723,152	-183,457	24,539,695	30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,102,406	0	4,102,406	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	35.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	2,455,685	0	2,455,685	50.00
53.00	05300	ANESTHESIOLOGY	0	41,724	0	41,724	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,565,421	0	3,565,421	54.00
57.00	05700	CT SCAN	0	731,625	0	731,625	57.00
60.00	06000	LABORATORY	0	4,527,010	0	4,527,010	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,569,299	0	1,569,299	65.00
66.00	06600	PHYSICAL THERAPY	0	984,065	0	984,065	66.00
69.00	06900	ELECTROCARDIOLOGY	0	426,198	0	426,198	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	65,590	0	65,590	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,716,826	0	1,716,826	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,157,673	0	3,157,673	73.00
74.00	07400	RENAL DIALYSIS	0	121,628	0	121,628	74.00
75.01	07501	HYPERBARIC CHAMBER	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	0	672,599	0	672,599	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	2,785,400	0	2,785,400	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	0	1,261	0	1,261	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	90.03
90.04	09004	CLINIC #4	0	0	0	0	90.04
90.05	09005	WOUND CARE	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	9,096,884	0	9,096,884	91.00
91.01	09101	GOLDEN LIFE	0	1,223	0	1,223	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	60,745,669	-183,457	60,562,212	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	PUBLIC RELATIONS	0	530,048	0	530,048	194.00
194.01	07952	RESEARCH	0	134,060	0	134,060	194.01
194.02	07953	OPMH	0	1,653,054	0	1,653,054	194.02
194.10	07951	AUSTIN PRIDE	0	5,540	0	5,540	194.10

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		23.00	24.00	25.00	26.00		
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)	0	63,068,371	-183,457	62,884,914		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
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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	14,852	4,062	18,914	4.00
5.01	01160	COMMUNICATIONS	0	14,407	3,941	18,348	5.01
5.04	00570	ADMITTING	0	1,862	509	2,371	5.04
5.05	00580	BUSINESS OFFICE	0	39,754	10,874	50,628	5.05
5.06	00590	OTHER ADMINISTRATIVE	96,342	521,424	142,617	760,383	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	249,723	68,304	318,027	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	30,662	8,387	39,049	8.00
9.00	00900	HOUSEKEEPING	0	29,718	8,128	37,846	9.00
10.00	01000	DIETARY	0	78,848	21,566	100,414	10.00
11.00	01100	CAFETERIA	0	34,035	9,309	43,344	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	8,971	2,454	11,425	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	144,098	39,413	183,511	14.00
15.00	01500	PHARMACY	197,564	16,350	4,472	218,386	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	21,179	5,793	26,972	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	5,180	1,417	6,597	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	369,392	101,035	470,427	30.00
31.00	03100	INTENSIVE CARE UNIT	0	85,984	23,518	109,502	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	35.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	40,524	121,516	33,237	195,277	50.00
53.00	05300	ANESTHESIOLOGY	0	4,910	1,343	6,253	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,721	110,684	30,274	147,679	54.00
57.00	05700	CT SCAN	500	7,554	2,066	10,120	57.00
60.00	06000	LABORATORY	0	89,357	24,441	113,798	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	3,773	27,816	7,608	39,197	65.00
66.00	06600	PHYSICAL THERAPY	0	42,695	11,678	54,373	66.00
69.00	06900	ELECTROCARDIOLOGY	0	7,770	2,125	9,895	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,275	1,443	6,718	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.01	07501	HYPERBARIC CHAMBER	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	0	92,715	25,359	118,074	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	719	34,075	9,320	44,114	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	0	0	0	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	90.03
90.04	09004	CLINIC #4	0	0	0	0	90.04
90.05	09005	WOUND CARE	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	120,194	32,875	153,069	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	346,143	2,331,000	637,568	3,314,711	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	PUBLIC RELATIONS	0	0	0	137	194.00
194.01	07952	RESEARCH	0	3,777	1,033	4,810	194.01
194.02	07953	OPMH	0	48,374	13,231	61,605	194.02

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
194.10	07951	AUSTIN PRIDE	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	346,143	2,383,151	651,832	3,381,126	18,914	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			COMMUNICATIONS	ADMITTING	BUSINESS OFFICE	OTHER ADMINISTRATIVE	MAINTENANCE & REPAIRS	
			5.01	5.04	5.05	5.06	6.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS	18,440					5.01
5.04	00570	ADMITTING	183	2,657				5.04
5.05	00580	BUSINESS OFFICE	274	0	51,327			5.05
5.06	00590	OTHER ADMINISTRATIVE	5,386	0	0	769,696		5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	274	0	0	63,806	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	91	0	0	2,916	0	8.00
9.00	00900	HOUSEKEEPING	91	0	0	29,160	0	9.00
10.00	01000	DIETARY	456	0	0	27,419	0	10.00
11.00	01100	CAFETERIA	274	0	0	6,806	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	913	0	0	34,442	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	274	0	0	9,523	0	14.00
15.00	01500	PHARMACY	183	0	0	22,650	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	639	0	0	13,896	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	1,967	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,369	1,138	17,948	203,370	0	30.00
31.00	03100	INTENSIVE CARE UNIT	456	187	2,047	39,139	0	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0	35.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,734	62	1,391	19,437	0	50.00
53.00	05300	ANESTHESIOLOGY	91	6	142	263	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	730	50	1,780	36,442	0	54.00
57.00	05700	CT SCAN	0	32	1,402	8,100	0	57.00
60.00	06000	LABORATORY	548	291	6,929	47,399	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	183	208	2,633	16,095	0	65.00
66.00	06600	PHYSICAL THERAPY	639	18	424	8,573	0	66.00
69.00	06900	ELECTROCARDIOLOGY	274	53	1,106	4,487	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	91	0	4	568	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	26	818	4,231	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	359	4,950	15,208	0	73.00
74.00	07400	RENAL DIALYSIS	0	6	65	1,465	0	74.00
75.01	07501	HYPERBARIC CHAMBER	0	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	183	0	1,371	3,931	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	639	2	214	29,194	0	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	0	0	0	5	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	0	90.03
90.04	09004	CLINIC #4	0	0	0	0	0	90.04
90.05	09005	WOUND CARE	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	1,552	219	8,103	94,861	0	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,527	2,657	51,327	745,353	0	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	PUBLIC RELATIONS	91	0	0	6,386	0	194.00
194.01	07952	RESEARCH	0	0	0	1,464	0	194.01
194.02	07953	OPMH	639	0	0	16,425	0	194.02
194.10	07951	AUSTIN PRIDE	183	0	0	68	0	194.10
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)	18,440	2,657	51,327	769,696	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/21/2019 8:40 am

Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.04	00570	ADMITTING						5.04
5.05	00580	BUSINESS OFFICE						5.05
5.06	00590	OTHER ADMINISTRATIVE						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	382,868					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,618	49,677				8.00
9.00	00900	HOUSEKEEPING	7,383	0	74,995			9.00
10.00	01000	DIETARY	19,588	0	677	148,864		10.00
11.00	01100	CAFETERIA	8,455	0	3,943	0	62,925	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	2,229	0	0	0	3,983	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	35,799	0	2,028	0	1,064	14.00
15.00	01500	PHARMACY	4,062	0	901	0	1,581	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,262	0	677	0	1,977	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,287	0	0	0	368	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	91,769	32,428	19,610	143,501	26,180	30.00
31.00	03100	INTENSIVE CARE UNIT	21,361	2,363	3,606	5,363	2,949	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0	35.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	30,189	14,886	5,748	0	1,062	50.00
53.00	05300	ANESTHESIOLOGY	1,220	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,498	0	3,943	0	2,268	54.00
57.00	05700	CT SCAN	1,877	0	0	0	618	57.00
60.00	06000	LABORATORY	22,199	0	3,943	0	3,061	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	6,910	0	2,028	0	1,892	65.00
66.00	06600	PHYSICAL THERAPY	10,607	0	3,437	0	957	66.00
69.00	06900	ELECTROCARDIOLOGY	1,930	0	0	0	392	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,310	0	0	0	85	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.01	07501	HYPERBARIC CHAMBER	0	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	23,034	0	0	0	179	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	8,465	0	5,634	0	3,341	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	0	0	0	0	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	0	90.03
90.04	09004	CLINIC #4	0	0	0	0	0	90.04
90.05	09005	WOUND CARE	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	29,860	0	15,778	0	7,667	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0	96	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	369,912	49,677	71,953	148,864	59,720	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	PUBLIC RELATIONS	0	0	0	0	530	194.00
194.01	07952	RESEARCH	938	0	0	0	98	194.01
194.02	07953	OPMH	12,018	0	3,042	0	2,577	194.02
194.10	07951	AUSTIN PRIDE	0	0	0	0	0	194.10
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)	382,868	49,677	74,995	148,864	62,925	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
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Cost Center Description			MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			12.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.04	00570	ADMITTING						5.04
5.05	00580	BUSINESS OFFICE						5.05
5.06	00590	OTHER ADMINISTRATIVE						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0					12.00
13.00	01300	NURSING ADMINISTRATION	0	53,908				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	232,330			14.00
15.00	01500	PHARMACY	0	0	0	248,152		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	49,734	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	46,746	0	1,373	17,395	30.00
31.00	03100	INTENSIVE CARE UNIT	0	5,267	0	593	1,983	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0	35.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,895	0	936	1,348	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	137	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	35	1,724	54.00
57.00	05700	CT SCAN	0	0	0	0	1,358	57.00
60.00	06000	LABORATORY	0	0	0	0	6,713	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	2,551	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	411	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2	1,071	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	4	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	232,330	0	792	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	226,471	4,796	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	63	74.00
75.01	07501	HYPERBARIC CHAMBER	0	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	0	0	0	0	1,329	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	5,383	208	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	0	0	0	108	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	0	90.03
90.04	09004	CLINIC #4	0	0	0	0	0	90.04
90.05	09005	WOUND CARE	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	12,097	7,851	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	53,908	232,330	246,998	49,734	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	PUBLIC RELATIONS	0	0	0	0	0	194.00
194.01	07952	RESEARCH	0	0	0	0	0	194.01
194.02	07953	OPMH	0	0	0	1,154	0	194.02
194.10	07951	AUSTIN PRIDE	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		12.00	13.00	14.00	15.00	16.00	
202.00	TOTAL (sum lines 118 through 201)	0	53,908	232,330	248,152	49,734	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
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						11/21/2019 8:40 am		
Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS		
						SERVICES-SALARY & FRINGES	SERVICES-OTHER	
						APPRV	PRGM COSTS	
			17.00	19.00	20.00	21.00	22.00	
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	01160	COMMUNICATIONS						5.01
5.04	00570	ADMITTING						5.04
5.05	00580	BUSINESS OFFICE						5.05
5.06	00590	OTHER ADMINISTRATIVE						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	0					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
20.00	02000	NURSING SCHOOL	0		0			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0			10,267		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0				0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0					23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0					30.00
31.00	03100	INTENSIVE CARE UNIT	0					31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0					35.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0					50.00
53.00	05300	ANESTHESIOLOGY	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0					54.00
57.00	05700	CT SCAN	0					57.00
60.00	06000	LABORATORY	0					60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0					62.30
65.00	06500	RESPIRATORY THERAPY	0					65.00
66.00	06600	PHYSICAL THERAPY	0					66.00
69.00	06900	ELECTROCARDIOLOGY	0					69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0					70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0					71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0					73.00
74.00	07400	RENAL DIALYSIS	0					74.00
75.01	07501	HYBERBARIC CHAMBER	0					75.01
76.00	03550	O/P MENTAL HEALTH	0					76.00
76.10	03950	PARTIAL HOSPITALIZATION	0					76.10
76.97	07697	CARDIAC REHABILITATION	0					76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0					76.98
76.99	07699	LITHOTRIPSY	0					76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0					90.00
90.01	09001	CICERO CLINIC	0					90.01
90.02	09002	YMCA CLINIC	0					90.02
90.03	09003	NORTH AVENUE CLINIC	0					90.03
90.04	09004	CLINIC #4	0					90.04
90.05	09005	WOUND CARE	0					90.05
91.00	09100	EMERGENCY	0					91.00
91.01	09101	GOLDEN LIFE	0					91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0					99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0					99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0					99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0					99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	PUBLIC RELATIONS	0					194.00
194.01	07952	RESEARCH	0					194.01
194.02	07953	OPMH	0					194.02
194.10	07951	AUSTIN PRIDE	0					194.10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS		
					SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	
					21.00	22.00	
200.00	Cross Foot Adjustments		0	0	10,267	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	0	0	10,267	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/21/2019 8:40 am

Cost Center Description			PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.00	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	01160	COMMUNICATIONS					5.01
5.04	00570	ADMITTING					5.04
5.05	00580	BUSINESS OFFICE					5.05
5.06	00590	OTHER ADMINISTRATIVE					5.06
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
20.00	02000	NURSING SCHOOL					20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV					22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		1,077,995	0	1,077,995	30.00
31.00	03100	INTENSIVE CARE UNIT		195,643	0	195,643	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT		0	0	0	35.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		274,256	0	274,256	50.00
53.00	05300	ANESTHESIOLOGY		8,112	0	8,112	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		222,640	0	222,640	54.00
57.00	05700	CT SCAN		23,646	0	23,646	57.00
60.00	06000	LABORATORY		205,416	0	205,416	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY		72,044	0	72,044	65.00
66.00	06600	PHYSICAL THERAPY		79,621	0	79,621	66.00
69.00	06900	ELECTROCARDIOLOGY		19,277	0	19,277	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		8,792	0	8,792	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		238,197	0	238,197	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		251,784	0	251,784	73.00
74.00	07400	RENAL DIALYSIS		1,599	0	1,599	74.00
75.01	07501	HYPERBARIC CHAMBER		0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH		0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION		148,120	0	148,120	76.10
76.97	07697	CARDIAC REHABILITATION		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	76.98
76.99	07699	LITHOTRIPSY		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC		97,740	0	97,740	90.00
90.01	09001	CICERO CLINIC		0	0	0	90.01
90.02	09002	YMCA CLINIC		113	0	113	90.02
90.03	09003	NORTH AVENUE CLINIC		0	0	0	90.03
90.04	09004	CLINIC #4		0	0	0	90.04
90.05	09005	WOUND CARE		0	0	0	90.05
91.00	09100	EMERGENCY		333,199	0	333,199	91.00
91.01	09101	GOLDEN LIFE		96	0	96	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF		0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY		0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY		0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY		0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,258,290	0	3,258,290	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	PUBLIC RELATIONS		7,144	0	7,144	194.00
194.01	07952	RESEARCH		7,344	0	7,344	194.01
194.02	07953	OPMH		97,830	0	97,830	194.02
194.10	07951	AUSTIN PRIDE		251	0	251	194.10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		23.00	24.00	25.00	26.00		
200.00	Cross Foot Adjustments	0	10,267	0	10,267		200.00
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	0	3,381,126	0	3,381,126		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0083

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS ((PHONES)	ADMITTING (INPATIENT REVENUE)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5.01	5.04	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	176,663					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		176,663				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,101	1,101	35,228,348			4.00
5.01	01160	COMMUNICATIONS	1,068	1,068	171,182	202		5.01
5.04	00570	ADMITTING	138	138	192,043	2	53,134,481	5.04
5.05	00580	BUSINESS OFFICE	2,947	2,947	791,288	3	0	5.05
5.06	00590	OTHER ADMINISTRATIVE	38,653	38,653	7,313,297	59	0	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	18,512	18,512	1,417,960	3	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,273	2,273	4,740	1	0	8.00
9.00	00900	HOUSEKEEPING	2,203	2,203	958,998	1	0	9.00
10.00	01000	DIETARY	5,845	5,845	577,391	5	0	10.00
11.00	01100	CAFETERIA	2,523	2,523	191,261	3	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	665	665	1,705,453	10	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,682	10,682	243,323	3	0	14.00
15.00	01500	PHARMACY	1,212	1,212	724,361	2	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,570	1,570	578,315	7	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	384	384	90,132	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	27,383	27,383	8,835,513	15	22,721,613	30.00
31.00	03100	INTENSIVE CARE UNIT	6,374	6,374	1,539,226	5	3,748,175	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0	35.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,008	9,008	541,796	19	1,246,209	50.00
53.00	05300	ANESTHESIOLOGY	364	364	0	1	111,006	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,205	8,205	913,783	8	1,006,322	54.00
57.00	05700	CT SCAN	560	560	259,592	0	634,342	57.00
60.00	06000	LABORATORY	6,624	6,624	996,360	6	5,823,729	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,062	2,062	646,580	2	4,163,804	65.00
66.00	06600	PHYSICAL THERAPY	3,165	3,165	339,608	7	358,253	66.00
69.00	06900	ELECTROCARDIOLOGY	576	576	125,578	3	1,069,526	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	391	391	21,771	1	3,634	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	522,240	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	7,187,152	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	118,690	74.00
75.01	07501	HYPERBARIC CHAMBER	0	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	6,873	6,873	35,779	2	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,526	2,526	1,016,137	7	37,552	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	0	0	0	0	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	0	90.03
90.04	09004	CLINIC #4	0	0	0	0	0	90.04
90.05	09005	WOUND CARE	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	8,910	8,910	3,988,860	17	4,382,234	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	172,797	172,797	34,220,327	192	53,134,481	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	PUBLIC RELATIONS	0	0	254,259	1	0	194.00
194.01	07952	RESEARCH	280	280	64,224	0	0	194.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0083

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

Worksheet B-1

Date/Time Prepared:
11/21/2019 8:40 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS ((PHONES)	ADMITTING (INPATIENT REVENUE)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5.01	5.04	
194.02	07953	OPMH	3,586	3,586	689,538	7	0	194.02
194.10	07951	AUSTIN PRIDE	0	0	0	2	0	194.10
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)	2,383,151	651,832	4,599,929	428,458	245,638	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.489814	3.689692	0.130575	2,121.079208	0.004623	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			18,914	18,440	2,657	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000537	91.287129	0.000050	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: 14-0083

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

Worksheet B-1

Date/Time Prepared:
11/21/2019 8:40 am

Cost Center Description		BUSINESS OFFICE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	
		5.05	5A.06	5.06	6.00	7.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01160	COMMUNICATIONS					5.01
5.04	00570	ADMITTING					5.04
5.05	00580	BUSINESS OFFICE	93,990,857				5.05
5.06	00590	OTHER ADMINISTRATIVE	0	-14,779,136	48,289,235		5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	4,003,157	114,244	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	182,955	2,273	8.00
9.00	00900	HOUSEKEEPING	0	0	1,829,485	2,203	9.00
10.00	01000	DIETARY	0	0	1,720,273	5,845	10.00
11.00	01100	CAFETERIA	0	0	426,979	2,523	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	2,160,876	665	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	597,436	10,682	14.00
15.00	01500	PHARMACY	0	0	1,421,054	1,212	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	871,818	1,570	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	123,409	384	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	32,857,613	0	12,758,369	27,383	30.00
31.00	03100	INTENSIVE CARE UNIT	3,748,175	0	2,455,518	6,374	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	35.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,547,694	0	1,219,462	9,008	50.00
53.00	05300	ANESTHESIOLOGY	259,835	0	16,529	364	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,259,621	0	2,286,345	8,205	54.00
57.00	05700	CT SCAN	2,567,922	0	508,185	560	57.00
60.00	06000	LABORATORY	12,689,687	0	2,973,792	6,624	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	4,822,551	0	1,009,794	2,062	65.00
66.00	06600	PHYSICAL THERAPY	777,397	0	537,835	3,165	66.00
69.00	06900	ELECTROCARDIOLOGY	2,025,246	0	281,535	576	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,673	0	35,612	391	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,497,577	0	265,450	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,066,283	0	954,117	0	73.00
74.00	07400	RENAL DIALYSIS	118,690	0	91,910	0	74.00
75.01	07501	HYPERBARIC CHAMBER	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	2,511,850	0	246,659	6,873	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	392,349	0	1,831,634	2,526	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	0	0	312	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	90.03
90.04	09004	CLINIC #4	0	0	0	0	90.04
90.05	09005	WOUND CARE	0	0	0	0	90.05
91.00	09100	EMERGENCY	14,840,694	0	5,951,480	8,910	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	93,990,857	-14,779,136	46,761,980	110,378	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	PUBLIC RELATIONS	0	0	400,653	0	194.00
194.01	07952	RESEARCH	0	0	91,879	280	194.01
194.02	07953	OPMH	0	0	1,030,481	3,586	194.02
194.10	07951	AUSTIN PRIDE	0	0	4,242	0	194.10
200.00		Cross Foot Adjustments					200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0083

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

Worksheet B-1

Date/Time Prepared:
11/21/2019 8:40 am

Cost Center Description		BUSINESS OFFICE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	
		5.05	5A.06	5.06	6.00	7.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,764,456		14,779,136	0	5,228,339	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.029412		0.306054	0.000000	45.764670	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	51,327		769,696	0	382,868	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000546		0.015939	0.000000	3.351318	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: 14-0083

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

Worksheet B-1

Date/Time Prepared:
11/21/2019 8:40 am

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY))	HOUSEKEEPING (HOURS OF SERVICE))	DIETARY (MEALS SERVED))	CAFETERIA (FTES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	
		8.00	9.00	10.00	11.00	12.00	
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	01160	COMMUNICATIONS					5.01
5.04	00570	ADMITTING					5.04
5.05	00580	BUSINESS OFFICE					5.05
5.06	00590	OTHER ADMINISTRATIVE					5.06
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	257,967				8.00
9.00	00900	HOUSEKEEPING	0	33,795			9.00
10.00	01000	DIETARY	0	305	50,631		10.00
11.00	01100	CAFETERIA	0	1,777	0	34,185	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	2,164	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	914	0	578	14.00
15.00	01500	PHARMACY	0	406	0	859	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	305	0	1,074	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	200	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	168,395	8,836	48,807	14,223	30.00
31.00	03100	INTENSIVE CARE UNIT	12,273	1,625	1,824	1,602	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	35.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	77,299	2,590	0	577	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,777	0	1,232	54.00
57.00	05700	CT SCAN	0	0	0	336	57.00
60.00	06000	LABORATORY	0	1,777	0	1,663	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	914	0	1,028	65.00
66.00	06600	PHYSICAL THERAPY	0	1,549	0	520	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	213	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	46	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.01	07501	HYPERBARIC CHAMBER	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	0	0	0	97	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	2,539	0	1,815	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	0	0	0	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	90.03
90.04	09004	CLINIC #4	0	0	0	0	90.04
90.05	09005	WOUND CARE	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	7,110	0	4,165	91.00
91.01	09101	GOLDEN LIFE	0	0	0	52	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	257,967	32,424	50,631	32,444	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	PUBLIC RELATIONS	0	0	0	288	194.00
194.01	07952	RESEARCH	0	0	0	53	194.01
194.02	07953	OPMH	0	1,371	0	1,400	194.02
194.10	07951	AUSTIN PRIDE	0	0	0	0	194.10
200.00		Cross Foot Adjustments					200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0083

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

Worksheet B-1

Date/Time Prepared:
11/21/2019 8:40 am

Cost Center Description		LAUNDRY & LINEN SERVICE ((POUNDS OF LAUNDRY))	HOUSEKEEPING ((HOURS OF SERVICE))	DIETARY ((MEALS SERVED))	CAFETERIA (FTES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	
		8.00	9.00	10.00	11.00	12.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	342,972	2,490,226	2,536,737	804,062	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1.329519	73.686226	50.102447	23.520901	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	49,677	74,995	148,864	62,925	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.192571	2.219115	2.940175	1.840720	0.000000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0083

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			NURSING ADMINISTRATION ((DIRECT NRSNG HRS))	CENTRAL SERVICES & SUPPLY ((COSTED REQUIS))	PHARMACY ((COSTED REQUIS))	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE ((TIME SPENT))	
			13.00	14.00	15.00	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	01160	COMMUNICATIONS						5.01
5.04	00570	ADMITTING						5.04
5.05	00580	BUSINESS OFFICE						5.05
5.06	00590	OTHER ADMINISTRATIVE						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION	341,168					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	100				14.00
15.00	01500	PHARMACY	0	0	716,245			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	93,990,857		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	13,680	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	295,844	0	3,963	32,857,613	12,952	30.00
31.00	03100	INTENSIVE CARE UNIT	33,332	0	1,711	3,748,175	0	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0	35.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,992	0	2,702	2,547,694	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	259,835	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	101	3,259,621	0	54.00
57.00	05700	CT SCAN	0	0	0	2,567,922	0	57.00
60.00	06000	LABORATORY	0	0	0	12,689,687	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,822,551	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	777,397	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	6	2,025,246	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	7,673	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	100	0	1,497,577	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	653,665	9,066,283	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	118,690	0	74.00
75.01	07501	HYPERBARIC CHAMBER	0	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	0	0	0	2,511,850	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	15,538	392,349	312	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	0	0	312	0	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	0	90.03
90.04	09004	CLINIC #4	0	0	0	0	0	90.04
90.05	09005	WOUND CARE	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	34,915	14,840,694	416	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	341,168	100	712,913	93,990,857	13,680	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	PUBLIC RELATIONS	0	0	0	0	0	194.00
194.01	07952	RESEARCH	0	0	0	0	0	194.01
194.02	07953	OPMH	0	0	3,332	0	0	194.02
194.10	07951	AUSTIN PRIDE	0	0	0	0	0	194.10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0083

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

Worksheet B-1

Date/Time Prepared:
11/21/2019 8:40 am

Cost Center Description		NURSING ADMINISTRATION ((DIRECT NRSNG HRS))	CENTRAL SERVICES & SUPPLY ((COSTED REQUIS))	PHARMACY ((COSTED REQUIS))	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE ((TIME SPENT))	
		13.00	14.00	15.00	16.00	17.00	
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)	2,903,554	1,350,086	1,961,561	1,258,227	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	8.510628	13,500.860000	2.738673	0.013387	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	53,908	232,330	248,152	49,734	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.158010	2,323.300000	0.346462	0.000529	0.000000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0083

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

Worksheet B-1

Date/Time Prepared:
11/21/2019 8:40 am

Cost Center Description			NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS		PARAMED ED PRGM (ASSIGNED TIME)	
					SERVICES-SALAR Y & FRINGES APPRV ((ASSIGNED TIME))	SERVICES-OTHER PRGM COSTS APPRV ((ASSIGNED TIME))		
			19.00	20.00	21.00	22.00	23.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.04	00570	ADMITTING						5.04
5.05	00580	BUSINESS OFFICE						5.05
5.06	00590	OTHER ADMINISTRATIVE						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
20.00	02000	NURSING SCHOOL		0				20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			10,000			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)					0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	10,000	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0	0	0	35.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.01	07501	HYBERBARIC CHAMBER	0	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	0	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	0	0	0	0	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	0	90.03
90.04	09004	CLINIC #4	0	0	0	0	0	90.04
90.05	09005	WOUND CARE	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	10,000	0	0	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	PUBLIC RELATIONS	0	0	0	0	0	194.00
194.01	07952	RESEARCH	0	0	0	0	0	194.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0083

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

Worksheet B-1

Date/Time Prepared:
11/21/2019 8:40 am

Cost Center Description			NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS		PARAMED ED PRGM (ASSIGNED TIME)	
					SERVICES-SALAR Y & FRINGES APPRV ((ASSIGNED TIME))	SERVICES-OTHER PRGM COSTS APPRV ((ASSIGNED TIME))		
			19.00	20.00	21.00	22.00	23.00	
194.02	07953	OPMH	0	0	0	0	0	194.02
194.10	07951	AUSTIN PRIDE	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	0	183,457	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	18.345700	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	10,267	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	1.026700	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0			0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000			0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/21/2019 8:40 am

			Title XVIII			Hospital	PPS		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	22,721,613		22,721,613			30.00	
31.00	03100	INTENSIVE CARE UNIT	3,748,175		3,748,175			31.00	
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0		0			35.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,246,209	1,301,485	2,547,694	0.963885	0.000000	50.00	
53.00	05300	ANESTHESIOLOGY	111,006	148,829	259,835	0.160579	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,006,322	2,253,299	3,259,621	1.093815	0.000000	54.00	
57.00	05700	CT SCAN	634,342	1,933,580	2,567,922	0.284909	0.000000	57.00	
60.00	06000	LABORATORY	5,823,729	6,865,958	12,689,687	0.356747	0.000000	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30	
65.00	06500	RESPIRATORY THERAPY	4,163,804	658,747	4,822,551	0.325408	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	358,253	419,144	777,397	1.265846	0.000000	66.00	
69.00	06900	ELECTROCARDIOLOGY	1,069,526	955,720	2,025,246	0.210443	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	3,634	4,039	7,673	8.548156	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	522,240	975,337	1,497,577	1.146402	0.000000	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	7,187,152	1,879,131	9,066,283	0.348287	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	118,690	0	118,690	1.024754	0.000000	74.00	
75.01	07501	HYBERBARIC CHAMBER	0	0	0	0.000000	0.000000	75.01	
76.00	03550	O/P MENTAL HEALTH	0	0	0	0.000000	0.000000	76.00	
76.10	03950	PARTIAL HOSPITALIZATION	0	2,511,850	2,511,850	0.267770	0.000000	76.10	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98	
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	37,552	354,797	392,349	7.099292	0.000000	90.00	
90.01	09001	CICERO CLINIC	0	0	0	0.000000	0.000000	90.01	
90.02	09002	YMCA CLINIC	0	0	0	0.000000	0.000000	90.02	
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0.000000	0.000000	90.03	
90.04	09004	CLINIC #4	0	0	0	0.000000	0.000000	90.04	
90.05	09005	WOUND CARE	0	0	0	0.000000	0.000000	90.05	
91.00	09100	EMERGENCY	4,382,234	10,458,460	14,840,694	0.612969	0.000000	91.00	
91.01	09101	GOLDEN LIFE	0	0	0	0.000000	0.000000	91.01	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	10,136,000	10,136,000	0.160996	0.000000	92.00	
	OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0			99.10	
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20	
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30	
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40	
200.00		Subtotal (see instructions)	53,134,481	40,856,376	93,990,857			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	53,134,481	40,856,376	93,990,857			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/21/2019 8:40 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
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT			35.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.963885		50.00
53.00	05300	ANESTHESIOLOGY	0.160579		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1.093815		54.00
57.00	05700	CT SCAN	0.284909		57.00
60.00	06000	LABORATORY	0.356747		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0.325408		65.00
66.00	06600	PHYSICAL THERAPY	1.265846		66.00
69.00	06900	ELECTROCARDIOLOGY	0.210443		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8.548156		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.146402		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.348287		73.00
74.00	07400	RENAL DIALYSIS	1.024754		74.00
75.01	07501	HYPERBARIC CHAMBER	0.000000		75.01
76.00	03550	O/P MENTAL HEALTH	0.000000		76.00
76.10	03950	PARTIAL HOSPITALIZATION	0.267770		76.10
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	7.099292		90.00
90.01	09001	CICERO CLINIC	0.000000		90.01
90.02	09002	YMCA CLINIC	0.000000		90.02
90.03	09003	NORTH AVENUE CLINIC	0.000000		90.03
90.04	09004	CLINIC #4	0.000000		90.04
90.05	09005	WOUND CARE	0.000000		90.05
91.00	09100	EMERGENCY	0.612969		91.00
91.01	09101	GOLDEN LIFE	0.000000		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.160996		92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY			99.40
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: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/21/2019 8:40 am

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	24,723,152		24,723,152	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,102,406		4,102,406	0	0	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0		0	0	0	35.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,455,685		2,455,685	0	0	50.00
53.00	05300	ANESTHESIOLOGY	41,724		41,724	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,565,421		3,565,421	0	0	54.00
57.00	05700	CT SCAN	731,625		731,625	0	0	57.00
60.00	06000	LABORATORY	4,527,010		4,527,010	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,569,299	0	1,569,299	0	0	65.00
66.00	06600	PHYSICAL THERAPY	984,065	0	984,065	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	426,198		426,198	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	65,590		65,590	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,716,826		1,716,826	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,157,673		3,157,673	0	0	73.00
74.00	07400	RENAL DIALYSIS	121,628		121,628	0	0	74.00
75.01	07501	HYBERBARIC CHAMBER	0		0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0		0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	672,599		672,599	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,785,400		2,785,400	0	0	90.00
90.01	09001	CICERO CLINIC	0		0	0	0	90.01
90.02	09002	YMCA CLINIC	1,261		1,261	0	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0		0	0	0	90.03
90.04	09004	CLINIC #4	0		0	0	0	90.04
90.05	09005	WOUND CARE	0		0	0	0	90.05
91.00	09100	EMERGENCY	9,096,884		9,096,884	0	0	91.00
91.01	09101	GOLDEN LIFE	1,223		1,223	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,644,054		1,644,054	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0		0		0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0		0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0		0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0		0	99.40
200.00		Subtotal (see instructions)	62,389,723	0	62,389,723	0	0	200.00
201.00		Less Observation Beds	1,644,054		1,644,054		0	201.00
202.00		Total (see instructions)	60,745,669	0	60,745,669	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/21/2019 8:40 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			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0		0			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0		0			35.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
75.01	07501	HYBERBARIC CHAMBER	0	0	0	0.000000	0.000000	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0.000000	0.000000	76.00
76.10	03950	PARTIAL HOSPITALIZATION	0	0	0	0.000000	0.000000	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	CICERO CLINIC	0	0	0	0.000000	0.000000	90.01
90.02	09002	YMCA CLINIC	0	0	0	0.000000	0.000000	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	CLINIC #4	0	0	0	0.000000	0.000000	90.04
90.05	09005	WOUND CARE	0	0	0	0.000000	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0.000000	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
200.00		Subtotal (see instructions)	0	0	0			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	0	0	0			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/21/2019 8:40 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
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT				35.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
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
60.00	06000	LABORATORY	0.000000			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
75.01	07501	HYPERBARIC CHAMBER	0.000000			75.01
76.00	03550	O/P MENTAL HEALTH	0.000000			76.00
76.10	03950	PARTIAL HOSPITALIZATION	0.000000			76.10
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
90.01	09001	CICERO CLINIC	0.000000			90.01
90.02	09002	YMCA CLINIC	0.000000			90.02
90.03	09003	NORTH AVENUE CLINIC	0.000000			90.03
90.04	09004	CLINIC #4	0.000000			90.04
90.05	09005	WOUND CARE	0.000000			90.05
91.00	09100	EMERGENCY	0.000000			91.00
91.01	09101	GOLDEN LIFE	0.000000			91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
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: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part I
Date/Time Prepared:
11/21/2019 8:40 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	1,077,995	0	1,077,995	17,850	60.39	30.00
31.00	INTENSIVE CARE UNIT	195,643		195,643	1,424	137.39	31.00
35.00	DETOXIFICATION INTENSIVE CARE UNIT	0		0	0	0.00	35.00
200.00	Total (lines 30 through 199)	1,273,638		1,273,638	19,274		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	3,202	193,369				30.00
31.00	INTENSIVE CARE UNIT	386	53,033				31.00
35.00	DETOXIFICATION INTENSIVE CARE UNIT	0	0				35.00
200.00	Total (lines 30 through 199)	3,588	246,402				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part II
Date/Time Prepared:
11/21/2019 8:40 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	274,256	2,547,694	0.107649	420,625	45,280	50.00
53.00	05300	ANESTHESIOLOGY	8,112	259,835	0.031220	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	222,640	3,259,621	0.068302	273,264	18,664	54.00
57.00	05700	CT SCAN	23,646	2,567,922	0.009208	171,927	1,583	57.00
60.00	06000	LABORATORY	205,416	12,689,687	0.016188	1,154,573	18,690	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	72,044	4,822,551	0.014939	860,867	12,860	65.00
66.00	06600	PHYSICAL THERAPY	79,621	777,397	0.102420	126,744	12,981	66.00
69.00	06900	ELECTROCARDIOLOGY	19,277	2,025,246	0.009518	320,400	3,050	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,792	7,673	1.145836	577	661	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	238,197	1,497,577	0.159055	127,403	20,264	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	251,784	9,066,283	0.027771	1,607,730	44,648	73.00
74.00	07400	RENAL DIALYSIS	1,599	118,690	0.013472	32,890	443	74.00
75.01	07501	HYBERBARIC CHAMBER	0	0	0.000000	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0.000000	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	148,120	2,511,850	0.058968	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	97,740	392,349	0.249115	987	246	90.00
90.01	09001	CICERO CLINIC	0	0	0.000000	0	0	90.01
90.02	09002	YMCA CLINIC	113	0	0.000000	0	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	CLINIC #4	0	0	0.000000	0	0	90.04
90.05	09005	WOUND CARE	0	0	0.000000	0	0	90.05
91.00	09100	EMERGENCY	333,199	14,840,694	0.022452	682,364	15,320	91.00
91.01	09101	GOLDEN LIFE	96	0	0.000000	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	71,686	10,136,000	0.007072	0	0	92.00
200.00		Total (lines 50 through 199)	2,056,338	67,521,069		5,780,351	194,690	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0083		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part III Date/Time Prepared: 11/21/2019 8:40 am		
					Title XVIII		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00	
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT		0	0	0	0	0	0	35.00	
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	17,850	0.00		3,202	30.00	
31.00	03100	INTENSIVE CARE UNIT			0	1,424	0.00		386	31.00	
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT			0	0	0.00		0	35.00	
200.00		Total (lines 30 through 199)			0	19,274			3,588	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	
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT		0						35.00	
200.00		Total (lines 30 through 199)		0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part IV
Date/Time Prepared:
11/21/2019 8:40 am

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.01	07501	HYPERBARIC CHAMBER	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	0	0	0	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	90.03
90.04	09004	CLINIC #4	0	0	0	0	90.04
90.05	09005	WOUND CARE	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part IV
Date/Time Prepared:
11/21/2019 8:40 am

Cost Center Description			Title XVIII		Hospital	PPS		
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	2,547,694	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	259,835	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,259,621	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	2,567,922	0.000000	57.00
60.00	06000	LABORATORY	0	0	0	12,689,687	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,822,551	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	777,397	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,025,246	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	7,673	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,497,577	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,066,283	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	118,690	0.000000	74.00
75.01	07501	HYBERBARIC CHAMBER	0	0	0	0	0.000000	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	0.000000	76.00
76.10	03950	PARTIAL HOSPITALIZATION	0	0	0	2,511,850	0.000000	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	392,349	0.000000	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	0.000000	90.01
90.02	09002	YMCA CLINIC	0	0	0	0	0.000000	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	CLINIC #4	0	0	0	0	0.000000	90.04
90.05	09005	WOUND CARE	0	0	0	0	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	14,840,694	0.000000	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	10,136,000	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	67,521,069		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0083

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

Worksheet D
Part IV
Date/Time Prepared:
11/21/2019 8:40 am

Cost Center Description		Title XVIII			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	420,625	0	327,451	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	273,264	0	351,373	0	54.00
57.00	05700	CT SCAN	0.000000	171,927	0	209,253	0	57.00
60.00	06000	LABORATORY	0.000000	1,154,573	0	341,233	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	860,867	0	105,790	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	126,744	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	320,400	0	175,037	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	577	0	1,154	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	127,403	0	105,044	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,607,730	0	245,225	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	32,890	0	0	0	74.00
75.01	07501	HYPERBARIC CHAMBER	0.000000	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0.000000	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	0.000000	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	987	0	45,872	0	90.00
90.01	09001	CICERO CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	CLINIC #4	0.000000	0	0	0	0	90.04
90.05	09005	WOUND CARE	0.000000	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.000000	682,364	0	731,834	0	91.00
91.01	09101	GOLDEN LIFE	0.000000	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	533,760	0	92.00
200.00		Total (lines 50 through 199)		5,780,351	0	3,173,026	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0083		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part V Date/Time Prepared: 11/21/2019 8:40 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		0.963885	327,451	0	0	315,625	50.00
53.00	05300	ANESTHESIOLOGY		0.160579	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		1.093815	351,373	0	0	384,337	54.00
57.00	05700	CT SCAN		0.284909	209,253	0	0	59,618	57.00
60.00	06000	LABORATORY		0.356747	341,233	0	0	121,734	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY		0.325408	105,790	0	0	34,425	65.00
66.00	06600	PHYSICAL THERAPY		1.265846	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0.210443	175,037	0	0	36,835	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		8.548156	1,154	0	0	9,865	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		1.146402	105,044	0	0	120,423	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.348287	245,225	0	3,831	85,409	73.00
74.00	07400	RENAL DIALYSIS		1.024754	0	0	0	0	74.00
75.01	07501	HYPERBARIC CHAMBER		0.000000	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH		0.000000	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION		0.267770	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		7.099292	45,872	0	0	325,659	90.00
90.01	09001	CICERO CLINIC		0.000000	0	0	0	0	90.01
90.02	09002	YMCA CLINIC		0.000000	0	0	0	0	90.02
90.03	09003	NORTH AVENUE CLINIC		0.000000	0	0	0	0	90.03
90.04	09004	CLINIC #4		0.000000	0	0	0	0	90.04
90.05	09005	WOUND CARE		0.000000	0	0	0	0	90.05
91.00	09100	EMERGENCY		0.612969	731,834	0	0	448,592	91.00
91.01	09101	GOLDEN LIFE		0.000000	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.160996	533,760	0	0	85,933	92.00
200.00		Subtotal (see instructions)			3,173,026	0	3,831	2,028,455	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0		201.00
202.00		Net Charges (line 200 - line 201)			3,173,026	0	3,831	2,028,455	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0083		Period: From 07/01/2018 To 06/30/2019	Worksheet D Part V Date/Time Prepared: 11/21/2019 8:40 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
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
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,334		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.01	07501	HYBERBARIC CHAMBER	0	0		75.01
76.00	03550	O/P MENTAL HEALTH	0	0		76.00
76.10	03950	PARTIAL HOSPITALIZATION	0	0		76.10
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CICERO CLINIC	0	0		90.01
90.02	09002	YMCA CLINIC	0	0		90.02
90.03	09003	NORTH AVENUE CLINIC	0	0		90.03
90.04	09004	CLINIC #4	0	0		90.04
90.05	09005	WOUND CARE	0	0		90.05
91.00	09100	EMERGENCY	0	0		91.00
91.01	09101	GOLDEN LIFE	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	1,334		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,334		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part I
Date/Time Prepared:
11/21/2019 8:40 am

			Title XIX		Hospital	Cost	
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	1,077,995	0	1,077,995	17,850	60.39	30.00
31.00	INTENSIVE CARE UNIT	195,643		195,643	1,424	137.39	31.00
35.00	DETOXIFICATION INTENSIVE CARE UNIT	0		0	0	0.00	35.00
200.00	Total (lines 30 through 199)	1,273,638		1,273,638	19,274		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	2,374	143,366				
31.00	INTENSIVE CARE UNIT	90	12,365				
35.00	DETOXIFICATION INTENSIVE CARE UNIT	0	0				
200.00	Total (lines 30 through 199)	2,464	155,731				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part II
Date/Time Prepared:
11/21/2019 8:40 am

Cost Center Description		Title XIX		Hospital		Cost	
		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	274,256	0	0.000000	0	50.00
53.00	05300	ANESTHESIOLOGY	8,112	0	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	222,640	0	0.000000	0	54.00
57.00	05700	CT SCAN	23,646	0	0.000000	0	57.00
60.00	06000	LABORATORY	205,416	0	0.000000	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	72,044	0	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	79,621	0	0.000000	0	66.00
69.00	06900	ELECTROCARDIOLOGY	19,277	0	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,792	0	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	238,197	0	0.000000	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	251,784	0	0.000000	0	73.00
74.00	07400	RENAL DIALYSIS	1,599	0	0.000000	0	74.00
75.01	07501	HYPERBARIC CHAMBER	0	0	0.000000	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0.000000	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	148,120	0	0.000000	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	97,740	0	0.000000	0	90.00
90.01	09001	CICERO CLINIC	0	0	0.000000	0	90.01
90.02	09002	YMCA CLINIC	113	0	0.000000	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0.000000	0	90.03
90.04	09004	CLINIC #4	0	0	0.000000	0	90.04
90.05	09005	WOUND CARE	0	0	0.000000	0	90.05
91.00	09100	EMERGENCY	333,199	0	0.000000	0	91.00
91.01	09101	GOLDEN LIFE	96	0	0.000000	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	71,686	0	0.000000	0	92.00
200.00		Total (lines 50 through 199)	2,056,338	0		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0083		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part III Date/Time Prepared: 11/21/2019 8:40 am	
					Title XIX		Hospital		Cost	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT		0	0	0	0	0	0	35.00
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
					4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	17,850	0.00	2,374		30.00
31.00	03100	INTENSIVE CARE UNIT			0	1,424	0.00	90		31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT			0	0	0.00	0		35.00
200.00		Total (lines 30 through 199)			0	19,274		2,464		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
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT		0						35.00
200.00		Total (lines 30 through 199)		0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part IV
Date/Time Prepared:
11/21/2019 8:40 am

Cost Center Description		Title XIX		Hospital		Cost	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.01	07501	HYPERBARIC CHAMBER	0	0	0	0	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	90.01
90.02	09002	YMCA CLINIC	0	0	0	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	90.03
90.04	09004	CLINIC #4	0	0	0	0	90.04
90.05	09005	WOUND CARE	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0083

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

Worksheet D
Part IV
Date/Time Prepared:
11/21/2019 8:40 am

				Title XIX		Hospital	Cost	
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	0	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
60.00	06000	LABORATORY	0	0	0	0	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
75.01	07501	HYBERBARIC CHAMBER	0	0	0	0	0.000000	75.01
76.00	03550	O/P MENTAL HEALTH	0	0	0	0	0.000000	76.00
76.10	03950	PARTIAL HOSPITALIZATION	0	0	0	0	0.000000	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	CICERO CLINIC	0	0	0	0	0.000000	90.01
90.02	09002	YMCA CLINIC	0	0	0	0	0.000000	90.02
90.03	09003	NORTH AVENUE CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	CLINIC #4	0	0	0	0	0.000000	90.04
90.05	09005	WOUND CARE	0	0	0	0	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
91.01	09101	GOLDEN LIFE	0	0	0	0	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00
200.00	Total (lines 50 through 199)		0	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0083

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

Worksheet D
Part IV
Date/Time Prepared:
11/21/2019 8:40 am

Cost Center Description		Title XIX		Hospital		Cost	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
60.00	06000 LABORATORY	0.000000	0	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.01	07501 HYPERBARIC CHAMBER	0.000000	0	0	0	0	75.01
76.00	03550 O/P MENTAL HEALTH	0.000000	0	0	0	0	76.00
76.10	03950 PARTIAL HOSPITALIZATION	0.000000	0	0	0	0	76.10
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	09001 CICERO CLINIC	0.000000	0	0	0	0	90.01
90.02	09002 YMCA CLINIC	0.000000	0	0	0	0	90.02
90.03	09003 NORTH AVENUE CLINIC	0.000000	0	0	0	0	90.03
90.04	09004 CLINIC #4	0.000000	0	0	0	0	90.04
90.05	09005 WOUND CARE	0.000000	0	0	0	0	90.05
91.00	09100 EMERGENCY	0.000000	0	0	0	0	91.00
91.01	09101 GOLDEN LIFE	0.000000	0	0	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00	Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0083	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/21/2019 8:40 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)		17,850	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		17,850	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)		16,663	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)		3,202	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)		24,539,695	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)		24,539,695	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)		24,539,695	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)		1,374.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,402,014	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)		4,402,014	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0083

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

Worksheet D-1

Date/Time Prepared:

11/21/2019 8:40 am

Cost Center Description		Title XVIII			Hospital		PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)							42.00
	Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	4,102,406	1,424	2,880.90	386	1,112,027		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	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0.00	0	0		47.00
	Cost Center Description							
						1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,843,122		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					8,357,163		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)					246,402		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					194,690		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					441,092		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					7,916,071		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)					1,187		87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,374.77		88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,631,852		89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0083

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

Worksheet D-1

Date/Time Prepared:
11/21/2019 8:40 am

				Title XVIII		Hospital	PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00		
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,077,995	24,539,695	0.043929	1,631,852	71,686	90.00	
91.00	Nursing School cost	0	24,539,695	0.000000	1,631,852	0	91.00	
92.00	Allied health cost	0	24,539,695	0.000000	1,631,852	0	92.00	
93.00	All other Medical Education	0	24,539,695	0.000000	1,631,852	0	93.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0083	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/21/2019 8:40 am
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			17,850 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			17,850 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)			16,663 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			2,374 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)			24,723,152 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)			24,723,152 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)			24,723,152 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)			1,385.05 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			3,288,109 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)			3,288,109 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0083

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

Worksheet D-1

Date/Time Prepared:
11/21/2019 8:40 am

Cost Center Description		Title XIX		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	4,102,406	1,424	2,880.90	90	259,281	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	DETOXIFICATION INTENSIVE CARE UNIT	0	0	0.00	0	0	47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,547,390	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,187	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,385.05	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,644,054	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0083

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

Worksheet D-1

Date/Time Prepared:
11/21/2019 8:40 am

		Title XIX		Hospital	Cost	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	1,077,995	24,723,152	0.043603	1,644,054	71,686	90.00
91.00 Nursing School cost	0	24,723,152	0.000000	1,644,054	0	91.00
92.00 Allied health cost	0	24,723,152	0.000000	1,644,054	0	92.00
93.00 All other Medical Education	0	24,723,152	0.000000	1,644,054	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0083	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/21/2019 8:40 am
			Title XVIII	Hospital	PPS
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		4,247,618	30.00
31.00	03100	INTENSIVE CARE UNIT		945,700	31.00
35.00	02040	DETOXIFICATION INTENSIVE CARE UNIT		0	35.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.963885	420,625	50.00
53.00	05300	ANESTHESIOLOGY	0.160579	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1.093815	273,264	54.00
57.00	05700	CT SCAN	0.284909	171,927	57.00
60.00	06000	LABORATORY	0.356747	1,154,573	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.325408	860,867	65.00
66.00	06600	PHYSICAL THERAPY	1.265846	126,744	66.00
69.00	06900	ELECTROCARDIOLOGY	0.210443	320,400	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8.548156	577	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.146402	127,403	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.348287	1,607,730	73.00
74.00	07400	RENAL DIALYSIS	1.024754	32,890	74.00
75.01	07501	HYPERBARIC CHAMBER	0.000000	0	75.01
76.00	03550	O/P MENTAL HEALTH	0.000000	0	76.00
76.10	03950	PARTIAL HOSPITALIZATION	0.267770	0	76.10
76.97	07697	CARDIAC REHABILITATION	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	7.099292	987	90.00
90.01	09001	CICERO CLINIC	0.000000	0	90.01
90.02	09002	YMCA CLINIC	0.000000	0	90.02
90.03	09003	NORTH AVENUE CLINIC	0.000000	0	90.03
90.04	09004	CLINIC #4	0.000000	0	90.04
90.05	09005	WOUND CARE	0.000000	0	90.05
91.00	09100	EMERGENCY	0.612969	682,364	91.00
91.01	09101	GOLDEN LIFE	0.000000	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.160996	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,780,351	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)		5,780,351	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet E
Part A
Date/Time Prepared:
11/21/2019 8:40 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)			1,085,105	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			3,255,316	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)			167,941	2.00
2.01	Outlier reconciliation amount			0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)			0	2.02
3.00	Managed Care Simulated Payments			2,000,121	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			118.73	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.			2.00	11.00
12.00	Current year allowable FTE (see instructions)			2.00	12.00
13.00	Total allowable FTE count for the prior year.			1.66	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.			1.50	14.00
15.00	Sum of lines 12 through 14 divided by 3.			1.72	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			1.72	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.014487	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.013798	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.013798	21.00
22.00	IME payment adjustment (see instructions)			32,610	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			15,027	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)			32,610	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			15,027	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			27.72	30.00
31.00	Percentage of Medicaid patient days (see instructions)			64.88	31.00
32.00	Sum of lines 30 and 31			92.60	32.00
33.00	Allowable disproportionate share percentage (see instructions)			65.61	33.00
34.00	Disproportionate share adjustment (see instructions)			711,937	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0083	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prepared: 11/21/2019 8:40 am	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		6,766,695,164	8,272,872,447	35.00
35.01	Factor 3 (see instructions)		0.000301652	0.000217962	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		2,041,188	1,803,173	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		514,492	1,348,674	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,863,166		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)		7,116,075		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)			7,131,102	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			438,509	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).			35,409	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)			7,605,020	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			7,605,020	61.00
62.00	Deductibles billed to program beneficiaries			423,068	62.00
63.00	Coinsurance billed to program beneficiaries			154,899	63.00
64.00	Allowable bad debts (see instructions)			500,608	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			325,395	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			293,267	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			7,352,448	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			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)			-12,575	70.93
70.94	HRR adjustment amount (see instructions)			-330	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0083	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prepared: 11/21/2019 8:40 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		56,179	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		7,283,364	71.00
71.01	Sequestration adjustment (see instructions)		145,667	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		6,706,290	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)		431,407	74.00
75.00	Contested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		228,972	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/21/2019 8:40 am

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1,085,105	1,085,105		1,085,105	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,255,316		3,255,316	3,255,316	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	167,941	41,986	125,955	167,941	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	2,000,121	500,030	1,500,091	2,000,121	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.013798	0.013798	0.013798		5.00
6.00	IME payment adjustment (see instructions)	22.00	32,610	8,152	24,458	32,610	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	15,027	3,757	11,270	15,027	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	32,610	8,152	24,458	32,610	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	15,027	3,757	11,270	15,027	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.6561	0.6561	0.6561		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	711,937	177,984	533,953	711,937	11.00
11.01	Uncompensated care payments	36.00	1,863,166	514,492	1,348,674	1,863,166	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	7,116,075	1,827,719	5,288,356	7,116,075	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	7,131,102	1,831,476	5,299,626	7,131,102	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	438,509	110,528	327,981	438,509	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			1,942,004	5,627,607	7,569,611	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/21/2019 8:40 am

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	353,813	89,180	264,633	353,813	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	8,273	2,085	6,188	8,273	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0098	0.0098	0.0098		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	3,467	874	2,593	3,467	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.2062	0.2062	0.2062		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	72,956	18,389	54,567	72,956	25.00
26.00	Total prospective capital payments (see instructions)	12.00	438,509	110,528	327,981	438,509	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-12,575	-3,144	-9,431	-12,575	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-330	-82	-248	-330	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	56,179	56,179	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0083	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 11/21/2019 8:40 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		1,334	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		2,028,455	2.00
3.00	OPPS payments		749,507	3.00
4.00	Outlier payment (see instructions)		127,864	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		1,334	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		3,831	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)		3,831	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)		3,831	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		2,497	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		1,334	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)		877,371	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)		160,287	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)		718,418	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		8,600	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)		727,018	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		727,018	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)		90,106	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		58,569	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		57,598	36.00
37.00	Subtotal (see instructions)		785,587	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		785,587	40.00
40.01	Sequestration adjustment (see instructions)		15,712	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		782,977	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-13,102	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: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet E-1
Part I
Date/Time Prepared:
11/21/2019 8:40 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		6,706,290		782,977	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		6,706,290		782,977	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		431,407		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		13,102	6.02
7.00	Total Medicare program liability (see instructions)		7,137,697		769,875	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

Provider CCN: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet E-3
Part VII
Date/Time Prepared:
11/21/2019 8:40 am

		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		3,547,390		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		3,547,390	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		3,547,390	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		3,547,390	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		3,547,390	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0083	Period: From 07/01/2018 To 06/30/2019	Worksheet E-4 Date/Time Prepared: 11/21/2019 8:40 am	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.00	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.00	0.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		2.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	2.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	1.66		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	1.25		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	1.64		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.00	1.64		17.00
18.00	Per resident amount	101,123.70	101,123.70		18.00
19.00	Approved amount for resident costs	0	165,843	165,843	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			165,843	25.00
		Inpatient Part	Managed care		
		A			
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	3,588	1,411		26.00
27.00	Total Inpatient Days (see instructions)	18,087	18,087		27.00
28.00	Ratio of inpatient days to total inpatient days	0.198375	0.078012		28.00
29.00	Program direct GME amount	32,899	12,938		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		1,828		30.00
31.00	Net Program direct GME amount			44,009	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0083	Period: From 07/01/2018 To 06/30/2019	Worksheet E-4 Date/Time Prepared: 11/21/2019 8:40 am	
		Title XVIII	Hospital	PPS	
			1.00		
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			118,690	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)			8,357,163	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)			0	39.00
40.00	Primary payer payments (see instructions)			0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			8,357,163	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			2,029,789	42.00
43.00	Primary payer payments (see instructions)			0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			2,029,789	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			10,386,952	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.804583	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.195417	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			44,009	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			35,409	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			8,600	50.00

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

Provider CCN: 14-0083

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

Worksheet G

Date/Time Prepared:
11/21/2019 8:40 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	183,434	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	99,748,383	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-87,267,366	0	0	0	6.00
7.00	Inventory	350,334	0	0	0	7.00
8.00	Prepaid expenses	82,327	0	0	0	8.00
9.00	Other current assets	3,702,729	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)	16,799,841	0	0	0	11.00
FIXED ASSETS						
12.00	Land	429,028	0	0	0	12.00
13.00	Land improvements	52,143	0	0	0	13.00
14.00	Accumulated depreciation	-38,159	0	0	0	14.00
15.00	Buildings	42,020,712	0	0	0	15.00
16.00	Accumulated depreciation	-18,389,919	0	0	0	16.00
17.00	Leasehold improvements	83,192	0	0	0	17.00
18.00	Accumulated depreciation	-83,192	0	0	0	18.00
19.00	Fixed equipment	11,607,331	0	0	0	19.00
20.00	Accumulated depreciation	-13,560,704	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	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	22,120,432	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	2,800,055	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,800,055	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	41,720,328	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	6,516,515	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,443,605	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,960,120	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	10,682,867	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	10,682,867	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	20,642,987	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	21,077,341				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	21,077,341	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	41,720,328	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0083

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

Worksheet G-1

Date/Time Prepared:
11/21/2019 8:40 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		30,340,065		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-7,202,783				2.00
3.00	Total (sum of line 1 and line 2)		23,137,282		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	NET ASSETS RELEASED	0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		23,137,282		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	NET ASSETS			0		0	13.00
14.00	OTHER	2,059,006		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		2,059,006		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		21,078,276		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00	NET ASSETS RELEASED		0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00	NET ASSETS		0				13.00
14.00	OTHER		0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
11/21/2019 8:40 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	23,677,530		23,677,530	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)	23,677,530		23,677,530	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,818,600		3,818,600	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	DETOXIFICATION INTENSIVE CARE UNIT	0		0	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	3,818,600		3,818,600	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	27,496,130		27,496,130	17.00
18.00	Ancillary services	26,250,914	43,504,886	69,755,800	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	53,747,044	43,504,886	97,251,930	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		70,844,512		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	BAD DEBTS	5,221,692			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)		5,221,692		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)		76,066,204		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0083

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

Worksheet G-3

Date/Time Prepared:
11/21/2019 8:40 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	97,251,930	1.00
2.00	Less contractual allowances and discounts on patients' accounts	58,244,393	2.00
3.00	Net patient revenues (line 1 minus line 2)	39,007,537	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	76,066,204	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-37,058,667	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	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	153,620	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	11,237	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	2,774	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	0	24.00
24.01	OTHER MISC	23,137,230	24.01
25.00	Total other income (sum of lines 6-24)	23,304,861	25.00
26.00	Total (line 5 plus line 25)	-13,753,806	26.00
27.00	CLEARING	-6,551,023	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-6,551,023	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-7,202,783	29.00

CALCULATION OF CAPITAL PAYMENT

Provider CCN: 14-0083

Period:
From 07/01/2018
To 06/30/2019Worksheet L
Parts I-III
Date/Time Prepared:
11/21/2019 8:40 am

Title XVIII		Hospital	PPS
			1.00
PART I - FULLY PROSPECTIVE METHOD			
CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier	353,813	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	8,273	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)	49.55	3.00
4.00	Number of interns & residents (see instructions)	1.72	4.00
5.00	Indirect medical education percentage (see instructions)	0.98	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)	3,467	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	27.72	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	64.88	8.00
9.00	Sum of lines 7 and 8	92.60	9.00
10.00	Allowable disproportionate share percentage (see instructions)	20.62	10.00
11.00	Disproportionate share adjustment (see instructions)	72,956	11.00
12.00	Total prospective capital payments (see instructions)	438,509	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