

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: 14-0103	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 6/24/2020 11:04 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 6/24/2020	Time: 11:04 am
	2. ☐ Manually prepared 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 ST. BERNARD HOSPITAL (14-0103) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) ROBERT SPRINGER

Officer or Administrator of Provider(s)

CFO

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	802,168	42,023	0	0	1.00
2.00	Subprovider - IPF	0	19,259	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	821,427	42,023	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: 14-0103		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 6/24/2020 11:04 am		
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 326 W 64TH STREET			PO Box:				1.00			
2.00	City: CHICAGO			State: IL		Zip Code: 60621		County: COOK			
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
								V	XVIII	XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital			ST. BERNARD HOSPITAL	140103	16974	1	07/01/1967	N	P	P
4.00	Subprovider - IPF			ST. BERNARD HOSPITAL PSYCH UNIT	14S103	16974	4	01/01/1994	N	P	P
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										
18.00	Renal Dialysis										
19.00	Other										
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2019	12/31/2019		20.00	
21.00	Type of Control (see instructions)						1			21.00	
							1.00	2.00	3.00		
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y			22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			23.00	
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
				1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			1,638	0	114	0	9,591	1,355	24.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part I
Date/Time Prepared:
6/24/2020 11:04 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
						Urban/Rural S	Date of Geogr	
						1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
						Beginning:	Ending:	
						1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
						Y/N	Y/N	
						1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	Y	40.00
						V	XVIII	XIX
						1.00	2.00	3.00
Prospective Payment System (PPS)-Capital								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	Y	N
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals								
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					Y	N	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
				1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.					N		60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part I
Date/Time Prepared:
6/24/2020 11:04 am

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

Worksheet S-2
Part I
Date/Time Prepared:
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MCRIF32 - 16.1.168.0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0103	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 6/24/2020 11:04 am	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			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.		N	N	N
				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
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	0	0	0 118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0103		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 6/24/2020 11:04 am	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	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				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	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	161.00		
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							9.99	169.00
							Beginning	Ending	
							1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
							1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0103	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 6/24/2020 11:04 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	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.		Y	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/17/2020	Y
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: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part II
Date/Time Prepared:
6/24/2020 11:04 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?		N		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.	TONY	LEONE		41.00
42.00	Enter the employer/company name of the cost report preparer.	TONY LEONE, CPA			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	847/275-1023	TONY@LEONE-CONSULTING.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0103	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 6/24/2020 11:04 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.	CONSULTANT		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: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
6/24/2020 11:04 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	126	47,880	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)		126	47,880	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	10	3,650	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		136	51,530	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	60	21,900		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		196			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
6/24/2020 11:04 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)	3,637	2,449	16,044			1.00
2.00	HMO and other (see instructions)	2,217	9,591				2.00
3.00	HMO IPF Subprovider	1,180	8,120				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)	3,637	2,449	16,044			7.00
8.00	INTENSIVE CARE UNIT	696	162	2,859			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		494	1,484			13.00
14.00	Total (see instructions)	4,333	3,105	20,387	4.02	682.41	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,633	1,620	13,150	0.00	54.13	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				4.02	736.54	27.00
28.00	Observation Bed Days		0	1,337			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	2	11			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: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
6/24/2020 11:04 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	773	595	4,026	1.00
2.00 HMO and other (see instructions)			372	2,029		2.00
3.00 HMO IPF Subprovider				1,387		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	773	595	4,026	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	260	293	2,226	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part II
Date/Time Prepared:
6/24/2020 11:04 am

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	44,788,333	0	44,788,333	1,507,675.00	29.71
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		670,454	0	670,454	8,362.00	80.18
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		3,258,134	441,211	3,699,345	133,297.00	27.75
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,131,537	0	2,131,537	34,491.00	61.80
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		9,489,682	0	9,489,682		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		888,498	0	888,498		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part II
Date/Time Prepared:
6/24/2020 11:04 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	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	242,609	0	242,609	7,197.00	33.71	26.00
27.00	Administrative & General	5.00	5,437,785	0	5,437,785	172,702.00	31.49	27.00
28.00	Administrative & General under contract (see inst.)		955,875	0	955,875	12,827.00	74.52	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,414,813	0	2,414,813	97,240.00	24.83	30.00
31.00	Laundry & Linen Service	8.00	85,304	0	85,304	5,075.00	16.81	31.00
32.00	Housekeeping	9.00	1,484,247	0	1,484,247	99,570.00	14.91	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	910,650	-412,985	497,665	28,981.00	17.17	34.00
35.00	Dietary under contract (see instructions)		818,805	0	818,805	15,639.00	52.36	35.00
36.00	Cafeteria	11.00	0	372,638	372,638	21,563.00	17.28	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	932,404	0	932,404	33,134.00	28.14	38.00
39.00	Central Services and Supply	14.00	368,019	0	368,019	16,432.00	22.40	39.00
40.00	Pharmacy	15.00	1,352,428	0	1,352,428	39,749.00	34.02	40.00
41.00	Medical Records & Medical Records Library	16.00	605,013	0	605,013	27,539.00	21.97	41.00
42.00	Social Service	17.00	917,042	0	917,042	21,590.00	42.48	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part III
Date/Time Prepared:
6/24/2020 11:04 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)	45,892,559	0	45,892,559	1,527,779.00	30.04	1.00
2.00	Excluded area salaries (see instructions)	3,258,134	441,211	3,699,345	133,297.00	27.75	2.00
3.00	Subtotal salaries (line 1 minus line 2)	42,634,425	-441,211	42,193,214	1,394,482.00	30.26	3.00
4.00	Subtotal other wages & related costs (see inst.)	2,131,537	0	2,131,537	34,491.00	61.80	4.00
5.00	Subtotal wage-related costs (see inst.)	9,489,682	0	9,489,682	0.00	22.49	5.00
6.00	Total (sum of lines 3 thru 5)	54,255,644	-441,211	53,814,433	1,428,973.00	37.66	6.00
7.00	Total overhead cost (see instructions)	16,524,994	-40,347	16,484,647	599,238.00	27.51	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part IV
Date/Time Prepared:
6/24/2020 11:04 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	470,872	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	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)	6,042,686	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)	64,709	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)	113,065	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	401,534	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	3,281,553	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	11	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	3,750	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	10,378,180	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COST		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part V
Date/Time Prepared:
6/24/2020 11:04 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	2,131,537	10,378,180	1.00
2.00	Hospital	2,131,537	9,489,682	2.00
3.00	Subprovider - IPF	0	888,498	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0103	Period: From 01/01/2019 To 12/31/2019	Worksheet S-10 Date/Time Prepared: 6/24/2020 11:04 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)			0.448287	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			29,743,171	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			107,122,372	6.00
7.00	Medicaid cost (line 1 times line 6)			48,021,567	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)			18,278,396	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)			18,278,396	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)	8,505,148	638,880	9,144,028	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,812,747	638,880	4,451,627	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	3,812,747	638,880	4,451,627	23.00
			1.00		
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			2,497,529	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			751,497	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			1,156,150	27.01
28.00	Non-Medicare bad debt expense (see instructions)			1,341,379	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			1,005,976	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			5,457,603	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			23,735,999	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0103

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

Worksheet A

Date/Time Prepared:
6/24/2020 11:04 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		5,179,520	5,179,520	-2,357,740	2,821,780	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	3,415,977	3,415,977	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	242,609	7,294,477	7,537,086	-7,152	7,529,934	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,437,785	10,918,600	16,356,385	-109,034	16,247,351	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	2,414,813	3,509,255	5,924,068	-324,223	5,599,845	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	85,304	353,026	438,330	0	438,330	8.00
9.00	00900	HOUSEKEEPING	1,484,247	428,245	1,912,492	0	1,912,492	9.00
10.00	01000	DIETARY	910,650	1,893,686	2,804,336	-1,193,068	1,611,268	10.00
11.00	01100	CAFETERIA	0	0	0	1,147,534	1,147,534	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	932,404	169,064	1,101,468	-99,957	1,001,511	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	368,019	604,253	972,272	-159,467	812,805	14.00
15.00	01500	PHARMACY	1,352,428	1,329,433	2,681,861	-1,175,414	1,506,447	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	605,013	487,151	1,092,164	-641	1,091,523	16.00
17.00	01700	SOCIAL SERVICE	917,042	478,188	1,395,230	0	1,395,230	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	569,525	569,525	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,974,736	4,916,132	14,890,868	-3,201,191	11,689,677	30.00
31.00	03100	INTENSIVE CARE UNIT	2,242,299	405,348	2,647,647	-213,678	2,433,969	31.00
40.00	04000	SUBPROVIDER - IPF	2,677,311	872,730	3,550,041	192,328	3,742,369	40.00
43.00	04300	NURSERY	0	352,818	352,818	1,406,616	1,759,434	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,318,568	755,585	2,074,153	-677,897	1,396,256	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	67,468	67,468	1,115,841	1,183,309	52.00
53.00	05300	ANESTHESIOLOGY	27,585	2,381,176	2,408,761	-97,486	2,311,275	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,599,812	1,653,570	4,253,382	-101,801	4,151,581	54.00
60.00	06000	LABORATORY	2,124,789	2,605,041	4,729,830	-147,433	4,582,397	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	955,309	499,288	1,454,597	-248,372	1,206,225	65.00
66.00	06600	PHYSICAL THERAPY	571,072	150,843	721,915	-6,056	715,859	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,667,247	2,667,247	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	158,865	158,865	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,174,033	1,174,033	73.00
74.00	07400	RENAL DIALYSIS	0	560,186	560,186	-15,309	544,877	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,078,337	2,550,556	4,628,893	67,625	4,696,518	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	291,050	24,345	315,395	-4,147	311,248	90.01
91.00	09100	EMERGENCY	4,596,328	5,411,469	10,007,797	-1,464,704	8,543,093	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		89,654	89,654	-89,654	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44,207,510	55,941,107	100,148,617	221,167	100,369,784	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	94,261	94,261	60,214	154,475	192.00
192.01	19201	ADULT MOBILE UNIT	0	9,403	9,403	0	9,403	192.01
194.00	07950	OUTPATIENT PHARMACY	487,917	876,941	1,364,858	-337,059	1,027,799	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	55,678	55,678	194.01
194.02	07952	FUNDRAISING	92,906	7,088	99,994	0	99,994	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	44,788,333	56,928,800	101,717,133	0	101,717,133	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0103

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

Worksheet A

Date/Time Prepared:
6/24/2020 11:04 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-112,739	2,709,041	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-28,825	3,387,152	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-99,482	7,430,452	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,973,846	14,273,505	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-122,385	5,477,460	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	438,330	8.00
9.00	00900	HOUSEKEEPING	-45,213	1,867,279	9.00
10.00	01000	DIETARY	0	1,611,268	10.00
11.00	01100	CAFETERIA	-521,281	626,253	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	-48,667	952,844	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	812,805	14.00
15.00	01500	PHARMACY	0	1,506,447	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-23,466	1,068,057	16.00
17.00	01700	SOCIAL SERVICE	0	1,395,230	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	569,525	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,756,829	8,932,848	30.00
31.00	03100	INTENSIVE CARE UNIT	-12,000	2,421,969	31.00
40.00	04000	SUBPROVIDER - IPF	-240,801	3,501,568	40.00
43.00	04300	NURSERY	-264,915	1,494,519	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,396,256	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,183,309	52.00
53.00	05300	ANESTHESIOLOGY	-2,254,500	56,775	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-453,875	3,697,706	54.00
60.00	06000	LABORATORY	0	4,582,397	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	-22,710	1,183,515	65.00
66.00	06600	PHYSICAL THERAPY	0	715,859	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-2,337	2,664,910	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	158,865	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,174,033	73.00
74.00	07400	RENAL DIALYSIS	0	544,877	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-2,690,075	2,006,443	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	311,248	90.01
91.00	09100	EMERGENCY	-3,429,199	5,113,894	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-15,103,145	85,266,639	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	154,475	192.00
192.01	19201	ADULT MOBILE UNIT	0	9,403	192.01
194.00	07950	OUTPATIENT PHARMACY	0	1,027,799	194.00
194.01	07951	PUBLIC RELATIONS	0	55,678	194.01
194.02	07952	FUNDRAISING	0	99,994	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-15,103,145	86,613,988	200.00

RECLASSIFICATIONS

Provider CCN: 14-0103

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

Worksheet A-6

Date/Time Prepared:
6/24/2020 11:04 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASSIFY POST PARTUM					
1.00	NURSERY	43.00	1,266,616	225,914		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1,001,449	178,619		2.00
	TOTALS		2,268,065	404,533		
	B - RECLASSIFY INTERNS & RESIDENTS					
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	569,525		1.00
	TOTALS		0	569,525		
	C - RECLASSIFY MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,826,112		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
	TOTALS		0	2,826,112		
	D - RECLASSIFY DRUGS SOLD					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,174,033		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
	TOTALS		0	1,174,033		
	E - RECLASSIFY PSYCH DIETARY COSTS					
1.00	SUBPROVIDER - IPF	40.00	40,347	3,026		1.00
	TOTALS		40,347	3,026		
	G - RECLASSIFY EMERGENCY ROOM					
1.00	SUBPROVIDER - IPF	40.00	344,929	26,387		1.00
	TOTALS		344,929	26,387		
	H - RECLASSIFY DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,614,304		1.00
	TOTALS		0	2,614,304		
	I - RECLASSIFY PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	256,564		1.00
	TOTALS		0	256,564		
	J - RECLASSIFY INTEREST EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	89,654		1.00
	TOTALS		0	89,654		
	K - RECLASSIFY EQUIPMENT RENTAL					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	712,019		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00

RECLASSIFICATIONS

Provider CCN: 14-0103

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

Worksheet A-6

Date/Time Prepared:
6/24/2020 11:04 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
	TOTALS		0	712,019		
	L - RECLASSIFY CAFETERIA COSTS					
1.00	CAFETERIA	11.00	372,638	774,896		1.00
	TOTALS		372,638	774,896		
	O - ACC RECLASS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	55,935	4,279		1.00
	TOTALS		55,935	4,279		
	P - RECLASS PR COSTS					
1.00	PUBLIC RELATIONS	194.01	0	55,678		1.00
	TOTALS		0	55,678		
	Q - RECLASS IMPLANT COSTS					
1.00	IMPL. DEV. CHARGED TO	72.00	0	158,865		1.00
	PATIENTS					
	TOTALS		0	158,865		
	R - OP BEHAVIORAL HEALTH					
1.00	CLINIC	90.00	0	78,120		1.00
	TOTALS		0	78,120		
	S - 340B DRUGS RECLASS					
1.00	CLINIC	90.00	0	337,059		1.00
	TOTALS		0	337,059		
500.00	Grand Total: Increases		3,081,914	10,085,054		500.00

RECLASSIFICATIONS

Provider CCN: 14-0103

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

Worksheet A-6

Date/Time Prepared:
6/24/2020 11:04 am

	Decreases						6/24/2020 11:04 am
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASSIFY POST PARTUM						
1.00	ADULTS & PEDIATRICS	30.00	1,266,616	225,914	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	1,001,449	178,619	0		2.00
	TOTALS		2,268,065	404,533			
	B - RECLASSIFY INTERNS & RESIDENTS						
1.00	EMERGENCY	91.00	0	569,525	0		1.00
	TOTALS		0	569,525			
	C - RECLASSIFY MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	158,727	0		1.00
2.00	PHARMACY	15.00	0	12,099	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	511,241	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	211,349	0		4.00
5.00	SUBPROVIDER - IPF	40.00	0	14,374	0		5.00
6.00	NURSERY	43.00	0	82,083	0		6.00
7.00	OPERATING ROOM	50.00	0	518,821	0		7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	62,025	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	96,000	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	93,281	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,930	0		11.00
13.00	LABORATORY	60.00	0	44,938	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	240,615	0		14.00
16.00	PHYSICAL THERAPY	66.00	0	4,575	0		16.00
17.00	RENAL DIALYSIS	74.00	0	13,148	0		17.00
18.00	CLINIC	90.00	0	273,474	0		18.00
19.00	PARTIAL HOSPITALIZATION PROGRAM	90.01	0	1,163	0		19.00
20.00	EMERGENCY	91.00	0	482,269	0		20.00
	TOTALS		0	2,826,112			
	D - RECLASSIFY DRUGS SOLD						
1.00	PHARMACY	15.00		1,163,064	0		1.00
2.00	ADULTS & PEDIATRICS	30.00		1,682	0		2.00
3.00	INTENSIVE CARE UNIT	31.00		168	0		3.00
4.00	SUBPROVIDER - IPF	40.00		230	0		4.00
5.00	NURSERY	43.00		1,670	0		5.00
6.00	OPERATING ROOM	50.00		324	0		6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00		879	0		7.00
8.00	ANESTHESIOLOGY	53.00		1,486	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00		106	0		9.00
10.00	PHYSICAL THERAPY	66.00		318	0		10.00
11.00	CLINIC	90.00		2,992	0		11.00
12.00	PARTIAL HOSPITALIZATION PROGRAM	90.01		20	0		12.00
13.00	EMERGENCY	91.00		1,094	0		13.00
	TOTALS		0	1,174,033			
	E - RECLASSIFY PSYCH DIETARY COSTS						
1.00	DIETARY	10.00	40,347	3,026	0		1.00
	TOTALS		40,347	3,026			
	G - RECLASSIFY EMERGENCY ROOM						
1.00	EMERGENCY	91.00	344,929	26,387	0		1.00
	TOTALS		344,929	26,387			
	H - RECLASSIFY DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,614,304	9		1.00
	TOTALS		0	2,614,304			
	I - RECLASSIFY PROPERTY INSURANCE						
1.00	OPERATION OF PLANT	7.00	0	256,564	12		1.00
	TOTALS		0	256,564			
	J - RECLASSIFY INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	89,654	11		1.00
	TOTALS		0	89,654			
	K - RECLASSIFY EQUIPMENT RENTAL						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7,152	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	53,356	0		2.00
3.00	OPERATION OF PLANT	7.00	0	67,659	0		3.00
4.00	DIETARY	10.00	0	2,161	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	99,957	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	740	0		6.00
7.00	PHARMACY	15.00	0	251	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	641	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	15,670	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	2,161	0		10.00
11.00	SUBPROVIDER - IPF	40.00	0	129,637	0		11.00
12.00	NURSERY	43.00	0	2,161	0		12.00
13.00	OPERATING ROOM	50.00	0	158,752	0		13.00
14.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1,323	0		14.00

RECLASSIFICATIONS

Provider CCN: 14-0103

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

Worksheet A-6

Date/Time Prepared:
6/24/2020 11:04 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,091	0		15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	393	0		16.00
17.00	LABORATORY	60.00	0	102,495	0		17.00
18.00	RESPIRATORY THERAPY	65.00	0	4,828	0		18.00
19.00	RESPIRATORY THERAPY	65.00	0	2,929	0		19.00
20.00	PHYSICAL THERAPY	66.00	0	1,163	0		20.00
21.00	RENAL DIALYSIS	74.00	0	2,161	0		21.00
22.00	CLINIC	90.00	0	10,874	0		22.00
23.00	PARTIAL HOSPITALIZATION PROGRAM	90.01	0	2,964	0		23.00
24.00	EMERGENCY	91.00	0	40,500	0		24.00
	TOTALS		0	712,019			
L - RECLASSIFY CAFETERIA COSTS							
1.00	DIETARY	10.00	372,638	774,896	0		1.00
	TOTALS		372,638	774,896			
O - ACC RECLASS							
1.00	CLINIC	90.00	55,935	4,279	0		1.00
	TOTALS		55,935	4,279			
P - RECLASS PR COSTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	55,678	0		1.00
	TOTALS		0	55,678			
Q - RECLASS IMPLANT COSTS							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	158,865	0		1.00
	TOTALS		0	158,865			
R - OP BEHAVIORAL HEALTH							
1.00	SUBPROVIDER - IPF	40.00	0	78,120	0		1.00
	TOTALS		0	78,120			
S - 340B DRUGS RECLASS							
1.00	OUTPATIENT PHARMACY	194.00	0	337,059	0		1.00
	TOTALS		0	337,059			
500.00	Grand Total: Decreases		3,081,914	10,085,054			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part I
Date/Time Prepared:
6/24/2020 11:04 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	2,192,754	0	0	0	0	1.00
2.00	Land Improvements	4,620,915	28,355	0	28,355	0	2.00
3.00	Buildings and Fixtures	84,010,352	1,977,190	0	1,977,190	413,744	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	55,815,621	1,887,456	0	1,887,456	78,720	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	146,639,642	3,893,001	0	3,893,001	492,464	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	146,639,642	3,893,001	0	3,893,001	492,464	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,192,754	0				1.00
2.00	Land Improvements	4,649,270	0				2.00
3.00	Buildings and Fixtures	85,573,798	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	57,624,357	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	150,040,179	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	150,040,179	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part II
Date/Time Prepared:
6/24/2020 11:04 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	5,179,520	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,179,520	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	5,179,520				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	5,179,520				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part III
Date/Time Prepared:
6/24/2020 11:04 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	92,415,821	0	92,415,821	0.615940	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	57,624,358	0	57,624,358	0.384060	0	2.00
3.00	Total (sum of lines 1-2)	150,040,179	0	150,040,179	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	2,542,131	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,585,479	712,019	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,127,610	712,019	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	-89,654	256,564	0	0	2,709,041	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	89,654	0	0	0	3,387,152	2.00
3.00	Total (sum of lines 1-2)	0	256,564	0	0	6,096,193	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0103

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

Worksheet A-8

Date/Time Prepared:
6/24/2020 11:04 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		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-89,654	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		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	-10,134,398			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	-494,557	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	B	-23,466	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-26,724	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	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC REVENUE OFFSET	B	-95,747	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0103

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

Worksheet A-8

Date/Time Prepared:
6/24/2020 11:04 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
34.00	DISCOUNTS	B	-2,337	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	34.00
35.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.00
38.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	38.00
39.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	39.00
40.00	MEDICAL GROUP REVENUE	B	-1,240,605	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	ER PHYSICIAN BILLING EXPENSE	A	-235,098	EMERGENCY	91.00	0	41.00
42.00	OFFSET DENTAL CLINIC COSTS	A	-1,073,184	CLINIC	90.00	0	42.00
42.01	PEDS VAN	A	-316,716	CLINIC	90.00	0	42.01
43.00	OFFSET OTHER LOBBYING COSTS	A	-180,000	ADMINISTRATIVE & GENERAL	5.00	0	43.00
45.00	OFFSET SPECIAL NEEDS CLINIC	A	-365,508	CLINIC	90.00	0	45.00
45.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.01
45.02	OFFSET OH RELATED TO CLINICS	A	-99,482	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.02
45.03	OFFSET OH RELATED TO CLINICS	A	-440,073	ADMINISTRATIVE & GENERAL	5.00	0	45.03
45.04	OFFSET OH RELATED TO CLINICS	A	-23,085	CAP REL COSTS-BLDG & FIXT	1.00	9	45.04
45.05	OFFSET OH RELATED TO CLINICS	A	-28,825	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.05
45.06	OFFSET OH RELATED TO CLINICS	A	-122,385	OPERATION OF PLANT	7.00	0	45.06
45.07	OFFSET OH RELATED TO CLINICS	A	-45,213	HOUSEKEEPING	9.00	0	45.07
45.08	OFFSET OH RELATED TO CLINICS	A	-48,667	NURSING ADMINISTRATION	13.00	0	45.08
45.09	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.09
45.10	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.10
45.11	LOBBY DUES	A	-17,421	ADMINISTRATIVE & GENERAL	5.00	0	45.11
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-15,103,145				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: 14-0103

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

Worksheet A-8-2

Date/Time Prepared:
6/24/2020 11:04 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	ADULTS & PEDIATRICS	2,756,829	2,756,829	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	12,000	12,000	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	240,801	240,801	0	0	0	3.00
4.00	43.00	NURSERY	264,915	264,915	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	2,254,500	2,254,500	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	453,875	453,875	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	22,710	22,710	0	0	0	7.00
8.00	90.00	CLINIC	934,667	934,667	0	0	0	8.00
9.00	91.00	EMERGENCY	3,194,101	3,194,101	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			10,134,398	10,134,398	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	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	3.00
4.00	43.00	NURSERY	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	7.00
8.00	90.00	CLINIC	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	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	ADULTS & PEDIATRICS	0	0	0	2,756,829		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	12,000		2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	240,801		3.00
4.00	43.00	NURSERY	0	0	0	264,915		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	2,254,500		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	453,875		6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	22,710		7.00
8.00	90.00	CLINIC	0	0	0	934,667		8.00
9.00	91.00	EMERGENCY	0	0	0	3,194,101		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	10,134,398		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
6/24/2020 11:04 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,709,041	2,709,041			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,387,152		3,387,152		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,430,452	7,250	9,064	7,446,766	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,273,505	842,141	1,052,939	909,040	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	5,477,460	331,007	413,862	403,687	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	438,330	13,732	17,169	14,260	8.00
9.00	00900	HOUSEKEEPING	1,867,279	31,312	39,150	248,123	9.00
10.00	01000	DIETARY	1,611,268	39,588	49,498	83,195	10.00
11.00	01100	CAFETERIA	626,253	16,855	21,074	62,294	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	952,844	28,720	35,909	155,871	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	812,805	19,314	24,148	61,522	14.00
15.00	01500	PHARMACY	1,506,447	16,130	20,168	226,087	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,068,057	18,124	22,660	101,141	16.00
17.00	01700	SOCIAL SERVICE	1,395,230	10,355	12,947	153,303	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	569,525	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,932,848	213,377	266,789	1,288,345	30.00
31.00	03100	INTENSIVE CARE UNIT	2,421,969	48,475	60,609	374,847	31.00
40.00	04000	SUBPROVIDER - IPF	3,501,568	138,079	172,642	511,976	40.00
43.00	04300	NURSERY	1,494,519	13,097	16,376	211,741	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,396,256	95,325	119,186	220,426	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,183,309	39,027	48,795	167,413	52.00
53.00	05300	ANESTHESIOLOGY	56,775	3,371	4,215	4,611	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,697,706	75,993	95,015	434,613	54.00
60.00	06000	LABORATORY	4,582,397	63,101	78,896	355,203	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,183,515	50,052	62,581	159,700	65.00
66.00	06600	PHYSICAL THERAPY	715,859	39,552	49,453	95,467	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,664,910	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	158,865	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,174,033	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	544,877	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,006,443	91,567	114,488	338,087	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	311,248	11,490	14,367	48,655	90.01
91.00	09100	EMERGENCY	5,113,894	83,520	104,427	710,711	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	85,266,639	2,340,554	2,926,427	7,340,318	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	154,475	360,633	450,905	9,351	192.00
192.01	19201	ADULT MOBILE UNIT	9,403	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	1,027,799	7,854	9,820	81,566	194.00
194.01	07951	PUBLIC RELATIONS	55,678	0	0	0	194.01
194.02	07952	FUNDRAISING	99,994	0	0	15,531	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	86,613,988	2,709,041	3,387,152	7,446,766	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
6/24/2020 11:04 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,077,625					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	1,627,303	0	8,253,319			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	118,742	0	74,139	676,372		8.00
9.00	00900	HOUSEKEEPING	536,833	0	169,056	0	2,891,753	9.00
10.00	01000	DIETARY	438,027	0	213,742	0	77,163	10.00
11.00	01100	CAFETERIA	178,417	0	91,003	0	32,853	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	288,165	0	155,063	0	55,980	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	225,403	0	104,278	0	37,646	14.00
15.00	01500	PHARMACY	434,413	0	87,089	0	31,440	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	297,163	0	97,852	0	35,326	16.00
17.00	01700	SOCIAL SERVICE	386,032	0	55,906	0	20,183	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	139,871	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,628,161	0	1,152,048	323,575	415,903	30.00
31.00	03100	INTENSIVE CARE UNIT	713,669	0	261,722	57,660	94,485	31.00
40.00	04000	SUBPROVIDER - IPF	1,062,009	0	745,504	265,208	269,136	40.00
43.00	04300	NURSERY	426,284	0	70,715	29,929	25,529	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	449,728	0	514,670	0	185,802	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	353,296	0	210,709	0	76,068	52.00
53.00	05300	ANESTHESIOLOGY	16,939	0	18,201	0	6,571	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,056,867	0	410,295	0	148,121	54.00
60.00	06000	LABORATORY	1,247,513	0	340,689	0	122,993	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	357,546	0	270,235	0	97,558	65.00
66.00	06600	PHYSICAL THERAPY	221,115	0	213,546	0	77,093	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	654,483	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	39,016	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	288,334	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	133,818	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	626,406	0	494,382	0	178,478	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	94,740	0	62,038	0	22,397	90.01
91.00	09100	EMERGENCY	1,476,641	0	450,936	0	162,793	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,516,934	0	6,263,818	676,372	2,173,518	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	239,543	0	1,947,098	0	702,927	192.00
192.01	19201	ADULT MOBILE UNIT	2,309	0	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	276,793	0	42,403	0	15,308	194.00
194.01	07951	PUBLIC RELATIONS	13,674	0	0	0	0	194.01
194.02	07952	FUNDRAISING	28,372	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	17,077,625	0	8,253,319	676,372	2,891,753	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
6/24/2020 11:04 am

Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	2,512,481					10.00
11.00	01100	CAFETERIA	0	1,028,749				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	30,997	0	1,703,549		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	15,372	0	37,232	1,337,720	14.00
15.00	01500	PHARMACY	0	37,185	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	25,763	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	20,198	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,224,984	237,860	0	576,118	0	30.00
31.00	03100	INTENSIVE CARE UNIT	193,927	49,230	0	119,238	0	31.00
40.00	04000	SUBPROVIDER - IPF	1,093,570	105,329	0	255,120	0	40.00
43.00	04300	NURSERY	0	35,784	0	86,668	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	35,667	0	86,388	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	28,293	0	68,524	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,829	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	77,503	0	0	0	54.00
60.00	06000	LABORATORY	0	60,827	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	35,473	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	14,244	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,266,524	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	71,196	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	66,820	0	161,849	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	6,246	0	15,129	0	90.01
91.00	09100	EMERGENCY	0	122,744	0	297,283	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,512,481	1,007,364	0	1,703,549	1,337,720	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,152	0	0	0	192.00
192.01	19201	ADULT MOBILE UNIT	0	0	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	0	16,287	0	0	0	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	FUNDRAISING	0	1,946	0	0	0	194.02
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)	2,512,481	1,028,749	0	1,703,549	1,337,720	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0103

Period:
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Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		
					SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS	
					APPRV	APPRV	
		15.00	16.00	17.00	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
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
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	2,358,959				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,666,086			16.00
17.00	01700	SOCIAL SERVICE	0	0	2,054,154		17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	709,396	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	241,073	982,701	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	58,844	175,115	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	141,486	805,442	0	40.00
43.00	04300	NURSERY	0	24,608	90,896	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	66,264	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	21,965	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	22,484	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	179,837	0	0	54.00
60.00	06000	LABORATORY	0	385,087	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	115,806	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	13,362	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	59,799	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,140	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,358,959	101,908	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	18,210	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	21,768	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	634	0	0	90.01
91.00	09100	EMERGENCY	0	187,811	0	709,396	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,358,959	1,666,086	2,054,154	709,396	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	ADULT MOBILE UNIT	0	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	0	0	0	0	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	194.01
194.02	07952	FUNDRAISING	0	0	0	0	194.02
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)	2,358,959	1,666,086	2,054,154	709,396	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0103

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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
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
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,483,782	0	18,483,782	30.00
31.00	03100	INTENSIVE CARE UNIT	4,629,790	0	4,629,790	31.00
40.00	04000	SUBPROVIDER - IPF	9,067,069	0	9,067,069	40.00
43.00	04300	NURSERY	2,526,146	0	2,526,146	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,169,712	0	3,169,712	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,197,399	0	2,197,399	52.00
53.00	05300	ANESTHESIOLOGY	134,996	0	134,996	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,175,950	0	6,175,950	54.00
60.00	06000	LABORATORY	7,236,706	0	7,236,706	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,332,466	0	2,332,466	65.00
66.00	06600	PHYSICAL THERAPY	1,439,691	0	1,439,691	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,645,716	0	4,645,716	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	274,217	0	274,217	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,923,234	0	3,923,234	73.00
74.00	07400	RENAL DIALYSIS	696,905	0	696,905	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,100,288	0	4,100,288	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	586,944	0	586,944	90.01
91.00	09100	EMERGENCY	9,420,156	-709,396	8,710,760	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	81,041,167	-709,396	80,331,771	118.00
NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,868,084	0	3,868,084	192.00
192.01	19201	ADULT MOBILE UNIT	11,712	0	11,712	192.01
194.00	07950	OUTPATIENT PHARMACY	1,477,830	0	1,477,830	194.00
194.01	07951	PUBLIC RELATIONS	69,352	0	69,352	194.01
194.02	07952	FUNDRAISING	145,843	0	145,843	194.02
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	86,613,988	-709,396	85,904,592	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	7,250	9,064	16,314	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	842,141	1,052,939	1,895,080	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	331,007	413,862	744,869	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	13,732	17,169	30,901	8.00
9.00	00900	HOUSEKEEPING	0	31,312	39,150	70,462	9.00
10.00	01000	DIETARY	0	39,588	49,498	89,086	10.00
11.00	01100	CAFETERIA	0	16,855	21,074	37,929	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	28,720	35,909	64,629	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	19,314	24,148	43,462	14.00
15.00	01500	PHARMACY	0	16,130	20,168	36,298	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	18,124	22,660	40,784	16.00
17.00	01700	SOCIAL SERVICE	0	10,355	12,947	23,302	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	213,377	266,789	480,166	30.00
31.00	03100	INTENSIVE CARE UNIT	0	48,475	60,609	109,084	31.00
40.00	04000	SUBPROVIDER - IPF	0	138,079	172,642	310,721	40.00
43.00	04300	NURSERY	0	13,097	16,376	29,473	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	95,325	119,186	214,511	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	39,027	48,795	87,822	52.00
53.00	05300	ANESTHESIOLOGY	0	3,371	4,215	7,586	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	75,993	95,015	171,008	54.00
60.00	06000	LABORATORY	0	63,101	78,896	141,997	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	50,052	62,581	112,633	65.00
66.00	06600	PHYSICAL THERAPY	0	39,552	49,453	89,005	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	91,567	114,488	206,055	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	11,490	14,367	25,857	90.01
91.00	09100	EMERGENCY	0	83,520	104,427	187,947	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,340,554	2,926,427	5,266,981	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	360,633	450,905	811,538	192.00
192.01	19201	ADULT MOBILE UNIT	0	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	0	7,854	9,820	17,674	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	194.01
194.02	07952	FUNDRAISING	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,709,041	3,387,152	6,096,193	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0103

Period:
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,897,070					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	180,771	0	926,524			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	13,191	0	8,323	52,446		8.00
9.00	00900	HOUSEKEEPING	59,635	0	18,978	0	149,618	9.00
10.00	01000	DIETARY	48,659	0	23,995	0	3,992	10.00
11.00	01100	CAFETERIA	19,820	0	10,216	0	1,700	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	32,011	0	17,408	0	2,896	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	25,039	0	11,706	0	1,948	14.00
15.00	01500	PHARMACY	48,257	0	9,777	0	1,627	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	33,011	0	10,985	0	1,828	16.00
17.00	01700	SOCIAL SERVICE	42,883	0	6,276	0	1,044	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	15,538	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	291,932	0	129,330	25,090	21,519	30.00
31.00	03100	INTENSIVE CARE UNIT	79,279	0	29,381	4,471	4,889	31.00
40.00	04000	SUBPROVIDER - IPF	117,975	0	83,691	20,564	13,925	40.00
43.00	04300	NURSERY	47,354	0	7,938	2,321	1,321	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	49,959	0	57,777	0	9,613	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	39,246	0	23,654	0	3,936	52.00
53.00	05300	ANESTHESIOLOGY	1,882	0	2,043	0	340	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	117,403	0	46,060	0	7,664	54.00
60.00	06000	LABORATORY	138,582	0	38,246	0	6,364	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	39,718	0	30,337	0	5,048	65.00
66.00	06600	PHYSICAL THERAPY	24,563	0	23,973	0	3,989	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	72,704	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,334	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,030	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	14,865	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	69,585	0	55,500	0	9,234	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	10,524	0	6,964	0	1,159	90.01
91.00	09100	EMERGENCY	164,034	0	50,622	0	8,423	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,834,784	0	703,180	52,446	112,459	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	26,610	0	218,584	0	36,367	192.00
192.01	19201	ADULT MOBILE UNIT	257	0	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	30,748	0	4,760	0	792	194.00
194.01	07951	PUBLIC RELATIONS	1,519	0	0	0	0	194.01
194.02	07952	FUNDRAISING	3,152	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,897,070	0	926,524	52,446	149,618	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0103

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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	165,914					10.00
11.00	01100	CAFETERIA	0	69,801				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	2,103	0	119,388		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,043	0	2,609	85,942	14.00
15.00	01500	PHARMACY	0	2,523	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,748	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,370	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	80,893	16,139	0	40,377	0	30.00
31.00	03100	INTENSIVE CARE UNIT	12,806	3,340	0	8,356	0	31.00
40.00	04000	SUBPROVIDER - IPF	72,215	7,147	0	17,879	0	40.00
43.00	04300	NURSERY	0	2,428	0	6,074	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,420	0	6,054	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,920	0	4,802	0	52.00
53.00	05300	ANESTHESIOLOGY	0	124	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,259	0	0	0	54.00
60.00	06000	LABORATORY	0	4,127	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	2,407	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	966	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	81,368	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,574	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	4,534	0	11,343	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	424	0	1,060	0	90.01
91.00	09100	EMERGENCY	0	8,328	0	20,834	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	165,914	68,350	0	119,388	85,942	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	214	0	0	0	192.00
192.01	19201	ADULT MOBILE UNIT	0	0	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	0	1,105	0	0	0	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	FUNDRAISING	0	132	0	0	0	194.02
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)	165,914	69,801	0	119,388	85,942	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		
						SERVICES-SALAR	SERVICES-OTHER	
						Y & FRINGES APPRV	PRGM COSTS APPRV	
			15.00	16.00	17.00	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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
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	98,977					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	88,577				16.00
17.00	01700	SOCIAL SERVICE	0	0	75,211			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	15,538		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0		0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	12,808	35,980			30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,126	6,412			31.00
40.00	04000	SUBPROVIDER - IPF	0	7,517	29,491			40.00
43.00	04300	NURSERY	0	1,307	3,328			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	3,521	0			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,167	0			52.00
53.00	05300	ANESTHESIOLOGY	0	1,195	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,555	0			54.00
60.00	06000	LABORATORY	0	20,518	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
65.00	06500	RESPIRATORY THERAPY	0	6,153	0			65.00
66.00	06600	PHYSICAL THERAPY	0	710	0			66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,177	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	273	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	98,977	5,414	0			73.00
74.00	07400	RENAL DIALYSIS	0	967	0			74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,157	0			90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	34	0			90.01
91.00	09100	EMERGENCY	0	9,978	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	98,977	88,577	75,211	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0			192.00
192.01	19201	ADULT MOBILE UNIT	0	0	0			192.01
194.00	07950	OUTPATIENT PHARMACY	0	0	0			194.00
194.01	07951	PUBLIC RELATIONS	0	0	0			194.01
194.02	07952	FUNDRAISING	0	0	0			194.02
200.00		Cross Foot Adjustments				15,538	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	98,977	88,577	75,211	15,538	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
6/24/2020 11:04 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
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
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,137,063	0	1,137,063	30.00
31.00	03100	INTENSIVE CARE UNIT	261,965	0	261,965	31.00
40.00	04000	SUBPROVIDER - IPF	682,246	0	682,246	40.00
43.00	04300	NURSERY	102,008	0	102,008	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	344,338	0	344,338	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	162,914	0	162,914	52.00
53.00	05300	ANESTHESIOLOGY	13,180	0	13,180	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	357,901	0	357,901	54.00
60.00	06000	LABORATORY	350,612	0	350,612	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	196,646	0	196,646	65.00
66.00	06600	PHYSICAL THERAPY	143,415	0	143,415	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	157,249	0	157,249	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,181	0	9,181	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	136,421	0	136,421	73.00
74.00	07400	RENAL DIALYSIS	15,832	0	15,832	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	358,148	0	358,148	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	46,129	0	46,129	90.01
91.00	09100	EMERGENCY	451,722	0	451,722	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,926,970	0	4,926,970	118.00
NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,093,333	0	1,093,333	192.00
192.01	19201	ADULT MOBILE UNIT	257	0	257	192.01
194.00	07950	OUTPATIENT PHARMACY	55,258	0	55,258	194.00
194.01	07951	PUBLIC RELATIONS	1,519	0	1,519	194.01
194.02	07952	FUNDRAISING	3,318	0	3,318	194.02
200.00		Cross Foot Adjustments	15,538	0	15,538	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,096,193	0	6,096,193	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0103

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

Worksheet B-1

Date/Time Prepared:
6/24/2020 11:04 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	448,423					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		448,423				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,200	1,200	44,545,724			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	139,398	139,398	5,437,785	-17,077,625	69,536,363	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	54,791	54,791	2,414,813	0	6,626,016	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,273	2,273	85,304	0	483,491	8.00
9.00	00900	HOUSEKEEPING	5,183	5,183	1,484,247	0	2,185,864	9.00
10.00	01000	DIETARY	6,553	6,553	497,665	0	1,783,549	10.00
11.00	01100	CAFETERIA	2,790	2,790	372,638	0	726,476	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	4,754	4,754	932,404	0	1,173,344	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,197	3,197	368,019	0	917,789	14.00
15.00	01500	PHARMACY	2,670	2,670	1,352,428	0	1,768,832	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,000	3,000	605,013	0	1,209,982	16.00
17.00	01700	SOCIAL SERVICE	1,714	1,714	917,042	0	1,571,835	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	569,525	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	35,320	35,320	7,706,671	0	10,701,359	30.00
31.00	03100	INTENSIVE CARE UNIT	8,024	8,024	2,242,299	0	2,905,900	31.00
40.00	04000	SUBPROVIDER - IPF	22,856	22,856	3,062,587	0	4,324,265	40.00
43.00	04300	NURSERY	2,168	2,168	1,266,616	0	1,735,733	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	15,779	15,779	1,318,568	0	1,831,193	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,460	6,460	1,001,449	0	1,438,544	52.00
53.00	05300	ANESTHESIOLOGY	558	558	27,585	0	68,972	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,579	12,579	2,599,812	0	4,303,327	54.00
60.00	06000	LABORATORY	10,445	10,445	2,124,789	0	5,079,597	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	8,285	8,285	955,309	0	1,455,848	65.00
66.00	06600	PHYSICAL THERAPY	6,547	6,547	571,072	0	900,331	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	2,664,910	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	158,865	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,174,033	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	544,877	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	15,157	15,157	2,022,402	0	2,550,585	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	1,902	1,902	291,050	0	385,760	90.01
91.00	09100	EMERGENCY	13,825	13,825	4,251,399	0	6,012,552	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	387,428	387,428	43,908,966	-17,077,625	67,253,354	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	59,695	59,695	55,935	0	975,364	192.00
192.01	19201	ADULT MOBILE UNIT	0	0	0	0	9,403	192.01
194.00	07950	OUTPATIENT PHARMACY	1,300	1,300	487,917	0	1,127,039	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	55,678	194.01
194.02	07952	FUNDRAISING	0	0	92,906	0	115,525	194.02
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)	2,709,041	3,387,152	7,446,766		17,077,625	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.041262	7.553475	0.167171		0.245593	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			16,314		1,897,070	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000366		0.027282	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: 14-0103

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

Worksheet B-1

Date/Time Prepared:
6/24/2020 11:04 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
7.00	00700	OPERATION OF PLANT	0	253,034			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,273	33,537		8.00
9.00	00900	HOUSEKEEPING	0	5,183	0	245,578	9.00
10.00	01000	DIETARY	0	6,553	0	6,553	10.00
11.00	01100	CAFETERIA	0	2,790	0	2,790	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	4,754	0	4,754	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,197	0	3,197	14.00
15.00	01500	PHARMACY	0	2,670	0	2,670	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,000	0	3,000	16.00
17.00	01700	SOCIAL SERVICE	0	1,714	0	1,714	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	35,320	16,044	35,320	30.00
31.00	03100	INTENSIVE CARE UNIT	0	8,024	2,859	8,024	31.00
40.00	04000	SUBPROVIDER - IPF	0	22,856	13,150	22,856	40.00
43.00	04300	NURSERY	0	2,168	1,484	2,168	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	15,779	0	15,779	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,460	0	6,460	52.00
53.00	05300	ANESTHESIOLOGY	0	558	0	558	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,579	0	12,579	54.00
60.00	06000	LABORATORY	0	10,445	0	10,445	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	8,285	0	8,285	65.00
66.00	06600	PHYSICAL THERAPY	0	6,547	0	6,547	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	15,157	0	15,157	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	1,902	0	1,902	90.01
91.00	09100	EMERGENCY	0	13,825	0	13,825	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	192,039	33,537	184,583	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	59,695	0	59,695	192.00
192.01	19201	ADULT MOBILE UNIT	0	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	0	1,300	0	1,300	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	194.01
194.02	07952	FUNDRAISING	0	0	0	0	194.02
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	8,253,319	676,372	2,891,753	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	32.617431	20.167934	11.775293	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	926,524	52,446	149,618	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	3.661658	1.563825	0.609248	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: 14-0103

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAFETERIA (FTES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	52,869					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	1,593	0	751,839			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	790	0	16,432	2,984,976		14.00
15.00	01500	PHARMACY	1,911	0	0	0	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,324	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,038	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,224	0	254,262	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,530	0	52,624	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	5,413	0	112,594	0	0	40.00
43.00	04300	NURSERY	1,839	0	38,250	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,833	0	38,126	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,454	0	30,242	0	0	52.00
53.00	05300	ANESTHESIOLOGY	94	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,983	0	0	0	0	54.00
60.00	06000	LABORATORY	3,126	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	1,823	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	732	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,826,111	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	158,865	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	100	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,434	0	71,430	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	321	0	6,677	0	0	90.01
91.00	09100	EMERGENCY	6,308	0	131,202	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	51,770	0	751,839	2,984,976	100	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	162	0	0	0	0	192.00
192.01	19201	ADULT MOBILE UNIT	0	0	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	837	0	0	0	0	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	FUNDRAISING	100	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,028,749	0	1,703,549	1,337,720	2,358,959	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.458454	0.000000	2.265843	0.448151	23,589.590000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	69,801	0	119,388	85,942	98,977	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.320263	0.000000	0.158795	0.028792	989.770000	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: 14-0103

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	INTERNS & RESIDENTS			
				SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
		16.00	17.00	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
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
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	179,197,127				16.00
17.00	01700	SOCIAL SERVICE	0	33,537			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	100		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	25,927,405	16,044	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	6,328,712	2,859	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	15,216,865	13,150	0	0	40.00
43.00	04300	NURSERY	2,646,595	1,484	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,126,706	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,362,318	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	2,418,108	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,341,492	0	0	0	54.00
60.00	06000	LABORATORY	41,425,743	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	12,454,920	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,437,033	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,431,335	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	552,851	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,960,168	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,958,489	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,341,197	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	68,151	0	0	0	90.01
91.00	09100	EMERGENCY	20,199,039	0	100	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	179,197,127	33,537	100	0	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	ADULT MOBILE UNIT	0	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	0	0	0	0	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	194.01
194.02	07952	FUNDRAISING	0	0	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,666,086	2,054,154	709,396	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.009298	61.250380	7,093.960000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	88,577	75,211	15,538	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000494	2.242628	155.380000	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

COMPUTATION OF RATIO OF COSTS TO CHARGES					Provider CCN: 14-0103	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepared: 6/24/2020 11:04 am
					Title XVIII	Hospital	PPS
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
					Total Costs	RCE Disallowance	Total Costs
			1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	18,483,782		18,483,782	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,629,790		4,629,790	0	31.00
40.00	04000	SUBPROVIDER - IPF	9,067,069		9,067,069	0	40.00
43.00	04300	NURSERY	2,526,146		2,526,146	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,169,712		3,169,712	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,197,399		2,197,399	0	52.00
53.00	05300	ANESTHESIOLOGY	134,996		134,996	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,175,950		6,175,950	0	54.00
60.00	06000	LABORATORY	7,236,706		7,236,706	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,332,466	0	2,332,466	0	65.00
66.00	06600	PHYSICAL THERAPY	1,439,691	0	1,439,691	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,645,716		4,645,716	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	274,217		274,217	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,923,234		3,923,234	0	73.00
74.00	07400	RENAL DIALYSIS	696,905		696,905	0	74.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	4,100,288		4,100,288	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	586,944		586,944	0	90.01
91.00	09100	EMERGENCY	8,710,760		8,710,760	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,421,833		1,421,833	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	81,753,604	0	81,753,604	0	200.00
201.00		Less Observation Beds	1,421,833		1,421,833		201.00
202.00		Total (see instructions)	80,331,771	0	80,331,771	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
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			Title XVIII		Hospital	PPS		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	23,970,725		23,970,725			30.00
31.00	03100	INTENSIVE CARE UNIT	6,328,712		6,328,712			31.00
40.00	04000	SUBPROVIDER - IPF	15,216,865		15,216,865			40.00
43.00	04300	NURSERY	2,646,595		2,646,595			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,283,612	4,843,094	7,126,706	0.444765	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,494,918	867,400	2,362,318	0.930188	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	784,699	1,633,409	2,418,108	0.055827	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,897,336	13,444,156	19,341,492	0.319311	0.000000	54.00
60.00	06000	LABORATORY	19,438,315	21,987,428	41,425,743	0.174691	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	9,715,317	2,739,603	12,454,920	0.187273	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	575,214	861,819	1,437,033	1.001850	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,574,306	2,857,029	6,431,335	0.722356	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	350,090	202,761	552,851	0.496005	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,824,993	2,135,175	10,960,168	0.357954	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,958,489	0	1,958,489	0.355838	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	295,463	2,045,734	2,341,197	1.751364	0.000000	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	68,151	68,151	8.612405	0.000000	90.01
91.00	09100	EMERGENCY	4,143,042	16,055,997	20,199,039	0.431246	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	98,290	1,858,390	1,956,680	0.726656	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	107,596,981	71,600,146	179,197,127			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	107,596,981	71,600,146	179,197,127			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.444765		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.930188		52.00
53.00	05300	ANESTHESIOLOGY	0.055827		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.319311		54.00
60.00	06000	LABORATORY	0.174691		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0.187273		65.00
66.00	06600	PHYSICAL THERAPY	1.001850		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.722356		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.496005		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.357954		73.00
74.00	07400	RENAL DIALYSIS	0.355838		74.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1.751364		90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	8.612405		90.01
91.00	09100	EMERGENCY	0.431246		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.726656		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES					Provider CCN: 14-0103	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepared: 6/24/2020 11:04 am	
					Title XIX	Hospital	PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs		
						RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,483,782		18,483,782	0	18,483,782	30.00
31.00	03100	INTENSIVE CARE UNIT	4,629,790		4,629,790	0	4,629,790	31.00
40.00	04000	SUBPROVIDER - IPF	9,067,069		9,067,069	0	9,067,069	40.00
43.00	04300	NURSERY	2,526,146		2,526,146	0	2,526,146	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,169,712		3,169,712	0	3,169,712	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,197,399		2,197,399	0	2,197,399	52.00
53.00	05300	ANESTHESIOLOGY	134,996		134,996	0	134,996	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,175,950		6,175,950	0	6,175,950	54.00
60.00	06000	LABORATORY	7,236,706		7,236,706	0	7,236,706	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,332,466	0	2,332,466	0	2,332,466	65.00
66.00	06600	PHYSICAL THERAPY	1,439,691	0	1,439,691	0	1,439,691	66.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,645,716		4,645,716	0	4,645,716	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	274,217		274,217	0	274,217	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,923,234		3,923,234	0	3,923,234	73.00
74.00	07400	RENAL DIALYSIS	696,905		696,905	0	696,905	74.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	4,100,288		4,100,288	0	4,100,288	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	586,944		586,944	0	586,944	90.01
91.00	09100	EMERGENCY	8,710,760		8,710,760	0	8,710,760	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,421,833		1,421,833	0	1,421,833	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	81,753,604	0	81,753,604	0	81,753,604	200.00
201.00		Less Observation Beds	1,421,833		1,421,833		1,421,833	201.00
202.00		Total (see instructions)	80,331,771	0	80,331,771	0	80,331,771	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
6/24/2020 11:04 am

			Title XIX		Hospital	PPS		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	23,970,725		23,970,725			30.00
31.00	03100	INTENSIVE CARE UNIT	6,328,712		6,328,712			31.00
40.00	04000	SUBPROVIDER - IPF	15,216,865		15,216,865			40.00
43.00	04300	NURSERY	2,646,595		2,646,595			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,283,612	4,843,094	7,126,706	0.444765	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,494,918	867,400	2,362,318	0.930188	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	784,699	1,633,409	2,418,108	0.055827	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,897,336	13,444,156	19,341,492	0.319311	0.000000	54.00
60.00	06000	LABORATORY	19,438,315	21,987,428	41,425,743	0.174691	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	9,715,317	2,739,603	12,454,920	0.187273	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	575,214	861,819	1,437,033	1.001850	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,574,306	2,857,029	6,431,335	0.722356	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	350,090	202,761	552,851	0.496005	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,824,993	2,135,175	10,960,168	0.357954	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,958,489	0	1,958,489	0.355838	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	295,463	2,045,734	2,341,197	1.751364	0.000000	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	68,151	68,151	8.612405	0.000000	90.01
91.00	09100	EMERGENCY	4,143,042	16,055,997	20,199,039	0.431246	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	98,290	1,858,390	1,956,680	0.726656	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	107,596,981	71,600,146	179,197,127			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	107,596,981	71,600,146	179,197,127			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
6/24/2020 11:04 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.444765			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.930188			52.00
53.00	05300	ANESTHESIOLOGY	0.055827			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.319311			54.00
60.00	06000	LABORATORY	0.174691			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.187273			65.00
66.00	06600	PHYSICAL THERAPY	1.001850			66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.722356			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.496005			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.357954			73.00
74.00	07400	RENAL DIALYSIS	0.355838			74.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.751364			90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	8.612405			90.01
91.00	09100	EMERGENCY	0.431246			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.726656			92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

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

Provider CCN: 14-0103

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

Worksheet C
Part II
Date/Time Prepared:
6/24/2020 11:04 am

Cost Center Description		Title XIX			Hospital	PPS	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,169,712	344,338	2,825,374	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,197,399	162,914	2,034,485	0	52.00
53.00	05300	ANESTHESIOLOGY	134,996	13,180	121,816	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,175,950	357,901	5,818,049	0	54.00
60.00	06000	LABORATORY	7,236,706	350,612	6,886,094	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,332,466	196,646	2,135,820	0	65.00
66.00	06600	PHYSICAL THERAPY	1,439,691	143,415	1,296,276	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,645,716	157,249	4,488,467	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	274,217	9,181	265,036	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,923,234	136,421	3,786,813	0	73.00
74.00	07400	RENAL DIALYSIS	696,905	15,832	681,073	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	4,100,288	358,148	3,742,140	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	586,944	46,129	540,815	0	90.01
91.00	09100	EMERGENCY	8,710,760	451,722	8,259,038	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,421,833	87,467	1,334,366	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	47,046,817	2,831,155	44,215,662	0	200.00
201.00		Less Observation Beds	1,421,833	87,467	1,334,366	0	201.00
202.00		Total (line 200 minus line 201)	45,624,984	2,743,688	42,881,296	0	202.00

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

Provider CCN: 14-0103

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

Worksheet C
Part II
Date/Time Prepared:
6/24/2020 11:04 am

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	3,169,712	7,126,706	0.444765		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2,197,399	2,362,318	0.930188		52.00
53.00	05300 ANESTHESIOLOGY	134,996	2,418,108	0.055827		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	6,175,950	19,341,492	0.319311		54.00
60.00	06000 LABORATORY	7,236,706	41,425,743	0.174691		60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000		62.30
65.00	06500 RESPIRATORY THERAPY	2,332,466	12,454,920	0.187273		65.00
66.00	06600 PHYSICAL THERAPY	1,439,691	1,437,033	1.001850		66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4,645,716	6,431,335	0.722356		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	274,217	552,851	0.496005		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,923,234	10,960,168	0.357954		73.00
74.00	07400 RENAL DIALYSIS	696,905	1,958,489	0.355838		74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	4,100,288	2,341,197	1.751364		90.00
90.01	09001 PARTIAL HOSPITALIZATION PROGRAM	586,944	68,151	8.612405		90.01
91.00	09100 EMERGENCY	8,710,760	20,199,039	0.431246		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,421,833	1,956,680	0.726656		92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (sum of lines 50 thru 199)	47,046,817	131,034,230			200.00
201.00	Less Observation Beds	1,421,833	0			201.00
202.00	Total (line 200 minus line 201)	45,624,984	131,034,230			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part I
Date/Time Prepared:
6/24/2020 11:04 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	1,137,063	0	1,137,063	17,381	65.42	30.00
31.00	INTENSIVE CARE UNIT	261,965		261,965	2,859	91.63	31.00
40.00	SUBPROVIDER - IPF	682,246	0	682,246	13,150	51.88	40.00
43.00	NURSERY	102,008		102,008	1,484	68.74	43.00
200.00	Total (lines 30 through 199)	2,183,282		2,183,282	34,874		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	3,637	237,933				
31.00	INTENSIVE CARE UNIT	696	63,774				
40.00	SUBPROVIDER - IPF	1,633	84,720				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	5,966	386,427				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part II
Date/Time Prepared:
6/24/2020 11:04 am

Cost Center Description			Title XVIII		Hospital	PPS	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	344,338	7,126,706	0.048317	85,360	4,124
52.00	05200	DELIVERY ROOM & LABOR ROOM	162,914	2,362,318	0.068964	5,628	388
53.00	05300	ANESTHESIOLOGY	13,180	2,418,108	0.005451	135,461	738
54.00	05400	RADIOLOGY-DIAGNOSTIC	357,901	19,341,492	0.018504	1,240,819	22,960
60.00	06000	LABORATORY	350,612	41,425,743	0.008464	4,118,629	34,860
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0
65.00	06500	RESPIRATORY THERAPY	196,646	12,454,920	0.015789	2,137,232	33,745
66.00	06600	PHYSICAL THERAPY	143,415	1,437,033	0.099799	186,443	18,607
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	157,249	6,431,335	0.024450	1,048,077	25,625
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,181	552,851	0.016607	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	136,421	10,960,168	0.012447	1,521,840	18,942
74.00	07400	RENAL DIALYSIS	15,832	1,958,489	0.008084	678,892	5,488
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	358,148	2,341,197	0.152976	2,893	443
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	46,129	68,151	0.676865	0	0
91.00	09100	EMERGENCY	451,722	20,199,039	0.022364	664,787	14,867
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	87,467	1,956,680	0.044702	15,921	712
200.00		Total (lines 50 through 199)	2,831,155	131,034,230		11,841,982	181,499

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0103		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part III Date/Time Prepared: 6/24/2020 11:04 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	
40.00	04000	SUBPROVIDER - IPF		0	0	0	0	0	0	40.00	
43.00	04300	NURSERY		0	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	17,381	0.00	3,637	30.00		
31.00	03100	INTENSIVE CARE UNIT		0	0	2,859	0.00	696	31.00		
40.00	04000	SUBPROVIDER - IPF		0	0	13,150	0.00	1,633	40.00		
43.00	04300	NURSERY		0	0	1,484	0.00	0	43.00		
200.00		Total (lines 30 through 199)		0	0	34,874		5,966	200.00		
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0						30.00	
31.00	03100	INTENSIVE CARE UNIT		0						31.00	
40.00	04000	SUBPROVIDER - IPF		0						40.00	
43.00	04300	NURSERY		0						43.00	
200.00		Total (lines 30 through 199)		0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0103

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

Worksheet D
Part IV
Date/Time Prepared:
6/24/2020 11:04 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	91.00
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: 14-0103		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 6/24/2020 11:04 am	
			Title XVIII		Hospital		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	7,126,706	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,362,318	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,418,108	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	19,341,492	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	41,425,743	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	12,454,920	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,437,033	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,431,335	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	552,851	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,960,168	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,958,489	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	2,341,197	0.000000	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	68,151	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	20,199,039	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,956,680	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	131,034,230		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
6/24/2020 11:04 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	85,360	0	51,018	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	5,628	0	0	0
53.00	05300	ANESTHESIOLOGY	0.000000	135,461	0	63,037	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,240,819	0	1,120,598	0
60.00	06000	LABORATORY	0.000000	4,118,629	0	1,130,887	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0.000000	2,137,232	0	324,883	0
66.00	06600	PHYSICAL THERAPY	0.000000	186,443	0	944	0
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,048,077	0	264,341	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	37,764	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,521,840	0	229,158	0
74.00	07400	RENAL DIALYSIS	0.000000	678,892	0	0	0
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	2,893	0	220,823	0
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0
91.00	09100	EMERGENCY	0.000000	664,787	0	1,264,844	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	15,921	0	208,892	0
200.00		Total (lines 50 through 199)		11,841,982	0	4,917,189	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
6/24/2020 11:04 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	0.444765	51,018	0	0	22,691	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.930188	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.055827	63,037	0	0	3,519	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.319311	1,120,598	0	0	357,819	54.00	
60.00	06000	LABORATORY	0.174691	1,130,887	0	0	197,556	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	0.187273	324,883	0	0	60,842	65.00	
66.00	06600	PHYSICAL THERAPY	1.001850	944	0	0	946	66.00	
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.722356	264,341	0	0	190,948	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.496005	37,764	0	0	18,731	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.357954	229,158	0	0	82,028	73.00	
74.00	07400	RENAL DIALYSIS	0.355838	0	0	0	0	74.00	
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	1.751364	220,823	0	0	386,741	90.00	
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	8.612405	0	0	0	0	90.01	
91.00	09100	EMERGENCY	0.431246	1,264,844	0	0	545,459	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.726656	208,892	0	0	151,793	92.00	
200.00		Subtotal (see instructions)		4,917,189	0	0	2,019,073	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		4,917,189	0	0	2,019,073	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
6/24/2020 11:04 am

			Title XVIII		Hospital	PPS
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0		90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0103

Period:

Worksheet D

Component CCN: 14-S103

From 01/01/2019
To 12/31/2019Part II
Date/Time Prepared:
6/24/2020 11:04 am

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	344,338	7,126,706	0.048317	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	162,914	2,362,318	0.068964	15,484	1,068	52.00
53.00	05300	ANESTHESIOLOGY	13,180	2,418,108	0.005451	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	357,901	19,341,492	0.018504	23,917	443	54.00
60.00	06000	LABORATORY	350,612	41,425,743	0.008464	514,210	4,352	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	196,646	12,454,920	0.015789	16,065	254	65.00
66.00	06600	PHYSICAL THERAPY	143,415	1,437,033	0.099799	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	157,249	6,431,335	0.024450	4,521	111	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,181	552,851	0.016607	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	136,421	10,960,168	0.012447	163,714	2,038	73.00
74.00	07400	RENAL DIALYSIS	15,832	1,958,489	0.008084	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	358,148	2,341,197	0.152976	237	36	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	46,129	68,151	0.676865	0	0	90.01
91.00	09100	EMERGENCY	451,722	20,199,039	0.022364	160,497	3,589	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,956,680	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	2,743,688	131,034,230		898,645	11,891	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0103 Component CCN: 14-S103		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 6/24/2020 11:04 am	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0103 Component CCN: 14-S103		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 6/24/2020 11:04 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	7,126,706	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	2,362,318	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	2,418,108	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	19,341,492	0.000000	54.00
60.00	06000	LABORATORY		0	0	0	41,425,743	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	12,454,920	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	1,437,033	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	6,431,335	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	552,851	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	10,960,168	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	1,958,489	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	2,341,197	0.000000	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	68,151	0.000000	90.01
91.00	09100	EMERGENCY		0	0	0	20,199,039	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	1,956,680	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	131,034,230		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0103

Period:

Worksheet D

Component CCN: 14-S103

From 01/01/2019
To 12/31/2019Part IV
Date/Time Prepared:
6/24/2020 11:04 am

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	15,484	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	23,917	0	3,022	54.00
60.00	06000	LABORATORY	0.000000	514,210	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	16,065	0	2,670	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	4,521	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	163,714	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	237	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	160,497	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	92.00
200.00		Total (lines 50 through 199)		898,645	0	5,692	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0103 Component CCN: 14-S103		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part V Date/Time Prepared: 6/24/2020 11:04 am	
			Title XVIII		Subprovider - IPF		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	0.444765	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.930188	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.055827	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.319311	3,022	0	0	965	54.00
60.00	06000	LABORATORY	0.174691	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	0.187273	2,670	0	0	500	65.00
66.00	06600	PHYSICAL THERAPY	1.001850	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.722356	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.496005	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.357954	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.355838	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1.751364	0	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	8.612405	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.431246	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.726656	0	0	0	0	92.00
200.00		Subtotal (see instructions)		5,692	0	0	1,465	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		5,692	0	0	1,465	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0103

Period:

Worksheet D

Component CCN: 14-S103

From 01/01/2019
To 12/31/2019Part V
Date/Time Prepared:
6/24/2020 11:04 am

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description		Costs			
		Cost	Cost		
		Reimbursed	Reimbursed		
		Services Subject To Ded. & Coins. (see inst.)	Services Not Subject To Ded. & Coins. (see inst.)		
		6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program	0		201.00
		Only Charges			
202.00		Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part I
Date/Time Prepared:
6/24/2020 11:04 am

			Title XIX		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	1,137,063	0	1,137,063	17,381	65.42	30.00
31.00	INTENSIVE CARE UNIT	261,965		261,965	2,859	91.63	31.00
40.00	SUBPROVIDER - IPF	682,246	0	682,246	13,150	51.88	40.00
43.00	NURSERY	102,008		102,008	1,484	68.74	43.00
200.00	Total (lines 30 through 199)	2,183,282		2,183,282	34,874		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	2,449	160,214				
31.00	INTENSIVE CARE UNIT	162	14,844				
40.00	SUBPROVIDER - IPF	1,620	84,046				
43.00	NURSERY	494	33,958				
200.00	Total (lines 30 through 199)	4,725	293,062				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part II
Date/Time Prepared:
6/24/2020 11:04 am

Cost Center Description			Title XIX		Hospital	PPS	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	344,338	7,126,706	0.048317	0	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	162,914	2,362,318	0.068964	0	0 52.00
53.00	05300	ANESTHESIOLOGY	13,180	2,418,108	0.005451	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	357,901	19,341,492	0.018504	0	0 54.00
60.00	06000	LABORATORY	350,612	41,425,743	0.008464	0	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	196,646	12,454,920	0.015789	0	0 65.00
66.00	06600	PHYSICAL THERAPY	143,415	1,437,033	0.099799	0	0 66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	157,249	6,431,335	0.024450	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,181	552,851	0.016607	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	136,421	10,960,168	0.012447	0	0 73.00
74.00	07400	RENAL DIALYSIS	15,832	1,958,489	0.008084	0	0 74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0 76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	358,148	2,341,197	0.152976	0	0 90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	46,129	68,151	0.676865	0	0 90.01
91.00	09100	EMERGENCY	451,722	20,199,039	0.022364	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	87,467	1,956,680	0.044702	0	0 92.00
200.00		Total (lines 50 through 199)	2,831,155	131,034,230		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0103		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part III Date/Time Prepared: 6/24/2020 11:04 am	
					Title XIX		Hospital		PPS	
Cost Center Description					Nursing School	Nursing School	Allied Health	Allied Health	All Other	
					Post-Stepdown Adjustments		Post-Stepdown Adjustments	Cost	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
40.00	04000	SUBPROVIDER - IPF		0	0	0	0	0	0	40.00
43.00	04300	NURSERY		0	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
					4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	17,381	0.00	2,449	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	0	2,859	0.00	162	31.00	
40.00	04000	SUBPROVIDER - IPF		0	0	13,150	0.00	1,620	40.00	
43.00	04300	NURSERY		0	0	1,484	0.00	494	43.00	
200.00		Total (lines 30 through 199)		0	0	34,874		4,725	200.00	
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
					9.00					
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0					30.00	
31.00	03100	INTENSIVE CARE UNIT		0					31.00	
40.00	04000	SUBPROVIDER - IPF		0					40.00	
43.00	04300	NURSERY		0					43.00	
200.00		Total (lines 30 through 199)		0					200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0103		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 6/24/2020 11:04 am	
			Title XIX		Hospital		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
6/24/2020 11:04 am

			Title XIX		Hospital	PPS		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	7,126,706	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,362,318	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,418,108	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	19,341,492	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	41,425,743	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	12,454,920	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,437,033	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,431,335	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	552,851	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,960,168	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,958,489	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	2,341,197	0.000000	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	68,151	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	20,199,039	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,956,680	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	131,034,230		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
6/24/2020 11:04 am

Cost Center Description			Title XIX		Hospital		PPS
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
			9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0 52.00
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
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0 74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0 76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	0	0	0	0 90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0 90.01
91.00	09100	EMERGENCY	0.000000	0	0	0	0 91.00
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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0103

Period:

Worksheet D

Component CCN: 14-S103

From 01/01/2019
To 12/31/2019Part II
Date/Time Prepared:
6/24/2020 11:04 am

Title XIX

Subprovider -
IPF

PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	344,338	7,126,706	0.048317	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	162,914	2,362,318	0.068964	0	52.00
53.00	05300	ANESTHESIOLOGY	13,180	2,418,108	0.005451	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	357,901	19,341,492	0.018504	0	54.00
60.00	06000	LABORATORY	350,612	41,425,743	0.008464	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	196,646	12,454,920	0.015789	0	65.00
66.00	06600	PHYSICAL THERAPY	143,415	1,437,033	0.099799	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	157,249	6,431,335	0.024450	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,181	552,851	0.016607	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	136,421	10,960,168	0.012447	0	73.00
74.00	07400	RENAL DIALYSIS	15,832	1,958,489	0.008084	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	358,148	2,341,197	0.152976	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	46,129	68,151	0.676865	0	90.01
91.00	09100	EMERGENCY	451,722	20,199,039	0.022364	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,956,680	0.000000	0	92.00
200.00		Total (lines 50 through 199)	2,743,688	131,034,230		0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0103 Component CCN: 14-S103		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 6/24/2020 11:04 am	
				Title XIX		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	0	0	90.01
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0103 Component CCN: 14-S103		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 6/24/2020 11:04 am	
			Title XIX		Subprovider - IPF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	7,126,706	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,362,318	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,418,108	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	19,341,492	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	41,425,743	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	12,454,920	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,437,033	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,431,335	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	552,851	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,960,168	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,958,489	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	2,341,197	0.000000	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	68,151	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	20,199,039	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,956,680	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	131,034,230		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0103 Component CCN: 14-S103		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 6/24/2020 11:04 am	
				Title XIX		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
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
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM		0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY		0.000000	0	0	0	0	91.00
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: 14-0103	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/24/2020 11:04 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)			17,381	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			17,381	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)			16,044	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			3,637	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)			18,483,782	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)			18,483,782	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)			18,483,782	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)			1,063.45	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			3,867,768	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)			3,867,768	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0103

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

Worksheet D-1

Date/Time Prepared:
6/24/2020 11:04 am

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,629,790	2,859	1,619.37	696	1,127,082
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,600,223
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					8,595,073
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					301,707
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					181,499
52.00	Total Program excludable cost (sum of lines 50 and 51)					483,206
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					8,111,867
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					1,337
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,063.45
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,421,833

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0103

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

Worksheet D-1

Date/Time Prepared:
6/24/2020 11:04 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	1,137,063	18,483,782	0.061517	1,421,833	87,467	90.00
91.00 Nursing School cost	0	18,483,782	0.000000	1,421,833	0	91.00
92.00 Allied health cost	0	18,483,782	0.000000	1,421,833	0	92.00
93.00 All other Medical Education	0	18,483,782	0.000000	1,421,833	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0103 Component CCN: 14-S103	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/24/2020 11:04 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		13,150	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		13,150	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		13,150	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,633	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)		9,067,069	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)		9,067,069	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)		9,067,069	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)		689.51	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,125,970	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)		1,125,970	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0103 Component CCN: 14-S103	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/24/2020 11:04 am
			Title XVIII	Subprovider - IPF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0
44.00 CORONARY CARE UNIT					
45.00 BURN INTENSIVE CARE UNIT					
46.00 SURGICAL INTENSIVE CARE UNIT					
47.00 OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					246,374
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,372,344
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					84,720
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					11,891
52.00 Total Program excludable cost (sum of lines 50 and 51)					96,611
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,275,733
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					
72.00 Program routine service cost (line 9 x line 71)					
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					
76.00 Per diem capital-related costs (line 75 ÷ line 2)					
77.00 Program capital-related costs (line 9 x line 76)					
78.00 Inpatient routine service cost (line 74 minus line 77)					
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					
81.00 Inpatient routine service cost per diem limitation					
82.00 Inpatient routine service cost limitation (line 9 x line 81)					
83.00 Reasonable inpatient routine service costs (see instructions)					
84.00 Program inpatient ancillary services (see instructions)					
85.00 Utilization review - physician compensation (see instructions)					
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					0
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0103 Component CCN: 14-S103		Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/24/2020 11:04 am	
		Title XVIII		Subprovider - IPF	PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	682,246	9,067,069	0.075244	0	0 90.00
91.00	Nursing School cost	0	9,067,069	0.000000	0	0 91.00
92.00	Allied health cost	0	9,067,069	0.000000	0	0 92.00
93.00	All other Medical Education	0	9,067,069	0.000000	0	0 93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0103

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

Worksheet D-1

Date/Time Prepared:

6/24/2020 11:04 am

Title XIX		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)	17,381	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	17,381	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)	16,044	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	2,449	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	1,484	15.00
16.00	Nursery days (title V or XIX only)	494	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)	18,483,782	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)	18,483,782	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)	18,483,782	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)	1,063.45	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,604,389	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,604,389	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0103

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

Worksheet D-1

Date/Time Prepared:
6/24/2020 11:04 am

		Title XIX		Hospital		PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	2,526,146	1,484	1,702.25	494	840,912	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	4,629,790	2,859	1,619.37	162	262,338	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,707,639	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)					209,016	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)					209,016	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,498,623	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)					1,337	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,063.45	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,421,833	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0103

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

Worksheet D-1

Date/Time Prepared:
6/24/2020 11:04 am

Cost Center Description		Title XIX		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,137,063	18,483,782	0.061517	1,421,833	87,467
91.00	Nursing School cost	0	18,483,782	0.000000	1,421,833	0
92.00	Allied health cost	0	18,483,782	0.000000	1,421,833	0
93.00	All other Medical Education	0	18,483,782	0.000000	1,421,833	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0103 Component CCN: 14-S103	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/24/2020 11:04 am
		Title XIX	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		13,150	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		13,150	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		13,150	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,620	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		1,484	15.00
16.00	Nursery days (title V or XIX only)		494	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)		9,067,069	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)		9,067,069	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)		9,067,069	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)		689.51	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,117,006	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)		1,117,006	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0103 Component CCN: 14-S103	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/24/2020 11:04 am	
				Title XIX		Subprovider - IPF	PPS
Cost Center Description		Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,117,006	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)					84,046	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)					84,046	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,032,960	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0103

Period:

Worksheet D-1

Component CCN: 14-S103

From 01/01/2019
To 12/31/2019Date/Time Prepared:
6/24/2020 11:04 am

Title XIX

Subprovider -
IPF

PPS

Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	682,246	9,067,069	0.075244	0	0	90.00
91.00	Nursing School cost	0	9,067,069	0.000000	0	0	91.00
92.00	Allied health cost	0	9,067,069	0.000000	0	0	92.00
93.00	All other Medical Education	0	9,067,069	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0103	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 6/24/2020 11:04 am	
Cost Center Description			Title XVIII	Hospital	PPS	
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		5,483,080		30.00
31.00	03100	INTENSIVE CARE UNIT		1,566,000		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.444765	85,360	37,965	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.930188	5,628	5,235	52.00
53.00	05300	ANESTHESIOLOGY	0.055827	135,461	7,562	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.319311	1,240,819	396,207	54.00
60.00	06000	LABORATORY	0.174691	4,118,629	719,487	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.187273	2,137,232	400,246	65.00
66.00	06600	PHYSICAL THERAPY	1.001850	186,443	186,788	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.722356	1,048,077	757,085	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.496005	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.357954	1,521,840	544,749	73.00
74.00	07400	RENAL DIALYSIS	0.355838	678,892	241,576	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.751364	2,893	5,067	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	8.612405	0	0	90.01
91.00	09100	EMERGENCY	0.431246	664,787	286,687	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.726656	15,921	11,569	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		11,841,982	3,600,223	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)		11,841,982		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0103 Component CCN: 14-S103	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 6/24/2020 11:04 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		1,884,035		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.444765	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.930188	15,484	14,403	52.00
53.00	05300 ANESTHESIOLOGY	0.055827	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.319311	23,917	7,637	54.00
60.00	06000 LABORATORY	0.174691	514,210	89,828	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.187273	16,065	3,009	65.00
66.00	06600 PHYSICAL THERAPY	1.001850	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.722356	4,521	3,266	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.496005	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.357954	163,714	58,602	73.00
74.00	07400 RENAL DIALYSIS	0.355838	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	1.751364	237	415	90.00
90.01	09001 PARTIAL HOSPITALIZATION PROGRAM	8.612405	0	0	90.01
91.00	09100 EMERGENCY	0.431246	160,497	69,214	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.726656	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		898,645	246,374	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)		898,645		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0103	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 6/24/2020 11:04 am	
Cost Center Description			Title XIX	Hospital	PPS	
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.444765	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.930188	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.055827	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.319311	0	0	54.00
60.00	06000	LABORATORY	0.174691	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.187273	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1.001850	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.722356	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.496005	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.357954	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.355838	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.751364	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	8.612405	0	0	90.01
91.00	09100	EMERGENCY	0.431246	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.726656	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00		Net charges (line 200 minus line 201)		0	0	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0103 Component CCN: 14-S103	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 6/24/2020 11:04 am	
		Title XIX	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
43.00	04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.444765	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.930188	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.055827	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.319311	0	0	54.00
60.00	06000 LABORATORY	0.174691	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.187273	0	0	65.00
66.00	06600 PHYSICAL THERAPY	1.001850	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.722356	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.496005	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.357954	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.355838	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	1.751364	0	0	90.00
90.01	09001 PARTIAL HOSPITALIZATION PROGRAM	8.612405	0	0	90.01
91.00	09100 EMERGENCY	0.431246	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.726656	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A
Date/Time Prepared:
6/24/2020 11:04 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)			4,461,602	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			1,258,422	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)			0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)			0	1.04
2.00	Outlier payments for discharges. (see instructions)				2.00
2.01	Outlier reconciliation amount			0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)			0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)			102,409	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			43,730	2.04
3.00	Managed Care Simulated Payments			2,747,274	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			137.52	4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)			3.03	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)			3.03	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			4.02	10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00	11.00
12.00	Current year allowable FTE (see instructions)			3.03	12.00
13.00	Total allowable FTE count for the prior year.			3.03	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.			3.03	14.00
15.00	Sum of lines 12 through 14 divided by 3.			3.03	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			3.03	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.022033	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.022240	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.022033	21.00
22.00	IME payment adjustment (see instructions)			68,463	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			32,882	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)			0.99	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)			68,463	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			32,882	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			25.49	30.00
31.00	Percentage of Medicaid patient days (see instructions)			62.25	31.00
32.00	Sum of lines 30 and 31			87.74	32.00
33.00	Allowable disproportionate share percentage (see instructions)			61.60	33.00
34.00	Disproportionate share adjustment (see instructions)			880,884	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0103	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 6/24/2020 11:04 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)		8,272,872,447	8,350,599,096
35.01	Factor 3 (see instructions)		0.000237450	0.000163718
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		1,964,391	1,367,146
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		1,469,256	343,654
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,812,910	
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	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.0000000	
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	
47.00	Subtotal (see instructions)		8,628,420	
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions))		0	
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		8,661,302	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		567,080	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).		70,992	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)		9,299,374	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		9,299,374	61.00
62.00	Deductibles billed to program beneficiaries		623,276	62.00
63.00	Coinurance billed to program beneficiaries		43,307	63.00
64.00	Allowable bad debts (see instructions)		813,693	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		528,900	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		609,018	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		9,161,691	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-6,210	70.93
70.94	HRR adjustment amount (see instructions)		-74,098	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0103	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 6/24/2020 11:04 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)		19,810	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		9,061,573	71.00	
71.01	Sequestration adjustment (see instructions)		181,231	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
71.03	Sequestration adjustment-PARHM pass-throughs			71.03	
72.00	Interim payments		8,078,174	72.00	
72.01	Interim payments-PARHM			72.01	
73.00	Tentative settlement (for contractor use only)		0	73.00	
73.01	Tentative settlement-PARHM (for contractor use only)			73.01	
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		802,168	74.00	
74.01	Balance due provider/program-PARHM (see instructions)			74.01	
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		234,302	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	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
6/24/2020 11:04 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,461,602	0	4,461,602		4,461,602
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,258,422	0		1,258,422	1,258,422
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	102,409	0	102,409		102,409
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	43,730	0		43,730	43,730
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	2,747,274	0	1,913,876	833,398	2,747,274
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.022033	0.022033	0.022033	0.022033	
6.00	IME payment adjustment (see instructions)	22.00	68,463	0	53,401	15,062	68,463
6.01	IME payment adjustment for managed care (see instructions)	22.01	32,882	0	22,907	9,975	32,882
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	68,463	0	53,401	15,062	68,463
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	32,882	0	22,907	9,975	32,882
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.6160	0.6160	0.6160	0.6160	
11.00	Disproportionate share adjustment (see instructions)	34.00	880,884	0	687,087	193,797	880,884
11.01	Uncompensated care payments	36.00	1,812,910	0	3,924,680	0	3,924,680
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	8,628,420	0	7,117,409	1,511,011	8,628,420
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	8,661,302	0	7,140,316	1,520,986	8,661,302
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	567,080	0	443,020	124,060	567,080

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
6/24/2020 11:04 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0
17.01	Net organ aquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	7,583,336	1,645,046	9,228,382
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	463,334	0	362,971	100,363	463,334
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	5,937	0	3,427	2,510	5,937
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0166	0.0166	0.0166	0.0166	
23.00	Indirect medical education adjustment (see instructions)	6.00	7,691	0	6,025	1,666	7,691
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1945	0.1945	0.1945	0.1945	
25.00	Disproportionate share adjustment (see instructions)	11.00	90,118	0	70,597	19,521	90,118
26.00	Total prospective capital payments (see instructions)	12.00	567,080	0	443,020	124,060	567,080
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.027321	0.027321	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			207,184		207,184
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				44,944	44,944
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
6/24/2020 11:04 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	4,461,602	4,461,602		4,461,602	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,258,422		1,258,422	1,258,422	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					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	102,409	102,409		102,409	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	43,730		43,730	43,730	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	2,747,274	1,913,876	833,398	2,747,274	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.022033	0.022033	0.022033		5.00
6.00	IME payment adjustment (see instructions)	22.00	68,463	53,401	15,062	68,463	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	32,882	22,907	9,975	32,882	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	68,463	53,401	15,062	68,463	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	32,882	22,907	9,975	32,882	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.6160	0.6160	0.6160		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	880,884	687,087	193,797	880,884	11.00
11.01	Uncompensated care payments	36.00	1,812,910	1,469,256	343,654	1,812,910	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	8,628,420	6,773,755	1,854,665	8,628,420	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	8,661,302	6,796,662	1,864,640	8,661,302	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	567,080	443,020	124,060	567,080	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			7,239,682	1,988,700	9,228,382	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
6/24/2020 11:04 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	463,334	362,971	100,363	463,334	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	5,937	3,427	2,510	5,937	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	0.0166	0.0166	0.0166		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	7,691	6,025	1,666	7,691	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1945	0.1945	0.1945		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	90,118	70,597	19,521	90,118	25.00
26.00	Total prospective capital payments (see instructions)	12.00	567,080	443,020	124,060	567,080	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	-6,210	-10,554	4,344	-6,210	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	-74,098	-62,017	-12,081	-74,098	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	19,810	19,810	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0103	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 6/24/2020 11:04 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		2,019,073	2.00
3.00	OPPS payments		1,555,269	3.00
4.00	Outlier payment (see instructions)		6,370	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)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	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)		0	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)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	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)		0	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)		1,561,639	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)		331,477	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)		1,230,162	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		14,391	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)		1,244,553	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,244,553	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)		267,033	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		173,571	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		203,180	36.00
37.00	Subtotal (see instructions)		1,418,124	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)		1,418,124	40.00
40.01	Sequestration adjustment (see instructions)		28,362	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		1,347,739	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		42,023	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0103 Component CCN: 14-S103	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 6/24/2020 11:04 am
		Title XVIII	Subprovider - IPF	PPS
			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		1,465	2.00
3.00	OPPS payments		1,213	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	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)		0	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)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	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)		0	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)		1,213	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)		243	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)		970	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		970	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		970	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		970	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		970	40.00
40.01	Sequestration adjustment (see instructions)		19	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		951	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		0	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part I
Date/Time Prepared:
6/24/2020 11:04 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		7,728,629		1,205,563	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		349,545		142,176	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) Program to Provider					3.00	
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)		8,078,174		1,347,739	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) Program to Provider					5.00	
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		802,168		42,023	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		8,880,342		1,389,762	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
			0	1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 14-0103 Component CCN: 14-S103		Period: From 01/01/2019 To 12/31/2019		Worksheet E-1 Part I Date/Time Prepared: 6/24/2020 11:04 am	
		Title XVIII		Subprovider - IPF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider						1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1,310,709		951		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)		28,786		0		3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,339,495		951		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		19,259		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		1,358,754		951		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part II
Date/Time Prepared:
6/24/2020 11:04 am

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0103 Component CCN: 14-S103	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part II Date/Time Prepared: 6/24/2020 11:04 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			1,532,157 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			36.027397 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			1,532,157 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			1,532,157 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			1,532,157 18.00
19.00	Deductibles			140,492 19.00
20.00	Subtotal (line 18 minus line 19)			1,391,665 20.00
21.00	Coinsurance			54,207 21.00
22.00	Subtotal (line 20 minus line 21)			1,337,458 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			75,424 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			49,026 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			35,026 25.00
26.00	Subtotal (sum of lines 22 and 24)			1,386,484 26.00
27.00	Direct graduate medical education payments (see instructions)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			1,386,484 31.00
31.01	Sequestration adjustment (see instructions)			27,730 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			1,339,495 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			19,259 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0103	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part VII Date/Time Prepared: 6/24/2020 11:04 am	
		Title XIX	Hospital	PPS	
			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		0		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)		0	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)		0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		14,141,517		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)		14,141,517	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)		14,141,517	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		14,141,517	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		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		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)		0	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	LESS INPATIENT COSTS		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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0103 Component CCN: 14-S103	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part VII Date/Time Prepared: 6/24/2020 11:04 am
		Title XIX	Subprovider - IPF	PPS
		Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	0		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)	0	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)	0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	5,474,388		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)	5,474,388	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)	5,474,388	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	5,474,388	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	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	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	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	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	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: 14-0103	Period: From 01/01/2019 To 12/31/2019	Worksheet E-4 Date/Time Prepared: 6/24/2020 11:04 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.			3.03	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)			3.03	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			4.02	6.00
7.00	Enter the lesser of line 5 or line 6			3.03	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	4.02	4.02	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	3.03	3.03	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		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	3.03		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	3.03		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	3.03		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	3.03		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	3.03		17.00
18.00	Per resident amount	0.00	101,715.42		18.00
19.00	Approved amount for resident costs	0	308,198	308,198	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)			0.99	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)			308,198	25.00
		Inpatient Part	Managed Care	Total	
		A			
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	5,966	3,397		26.00
27.00	Total Inpatient Days (see instructions)	32,064	32,064		27.00
28.00	Ratio of inpatient days to total inpatient days	0.186065	0.105944		28.00
29.00	Program direct GME amount	57,345	32,652	89,997	29.00
29.01	Percent reduction for MA DGME				29.01
30.00	Reduction for direct GME payments for Medicare Advantage		4,614	4,614	30.00
31.00	Net Program direct GME amount			85,383	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0103	Period: From 01/01/2019 To 12/31/2019	Worksheet E-4 Date/Time Prepared: 6/24/2020 11:04 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)		1,958,489	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)		9,967,417	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)		9,967,417	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		2,020,538	42.00
43.00	Primary payer payments (see instructions)		0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		2,020,538	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		11,987,955	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.831453	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.168547	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		85,383	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		70,992	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		14,391	50.00

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

Provider CCN: 14-0103

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

Worksheet G

Date/Time Prepared:
6/24/2020 11:04 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	8,466,013	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	13,614,467	0	0	0	4.00
5.00	Other receivable	407,700	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,102,934	0	0	0	7.00
8.00	Prepaid expenses	1,126,666	0	0	0	8.00
9.00	Other current assets	0	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)	24,717,780	0	0	0	11.00
FIXED ASSETS						
12.00	Land	6,842,022	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	86,941,973	0	0	0	15.00
16.00	Accumulated depreciation	-50,261,236	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	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	56,256,363	0	0	0	23.00
24.00	Accumulated depreciation	-44,725,153	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)	55,053,969	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	27,244	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	15,311,708	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	15,338,952	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	95,110,701	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	4,874,174	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,579,204	0	0	0	38.00
39.00	Payroll taxes payable	544,002	0	0	0	39.00
40.00	Notes and loans payable (short term)	89,301	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	-44,201	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	11,042,480	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	12,494,782	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	16,278,315	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	28,773,097	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	39,815,577	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	55,295,124				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)	55,295,124	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	95,110,701	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0103

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

Worksheet G-1

Date/Time Prepared:
6/24/2020 11:04 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		51,707,018		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-667,397				2.00
3.00	Total (sum of line 1 and line 2)		51,039,621		0		3.00
4.00	RECONCILING ITEM	3		0		0	4.00
5.00	GAINS ON INVESTMENTS	0		0		0	5.00
6.00	TEMPORARILY RESTRICTED	0		0		0	6.00
7.00	CONTRIBUTIONS	0		0		0	7.00
8.00	TRANSFERS	4,255,500		0		0	8.00
9.00	ASSETS RELEASED	0		0		0	9.00
10.00	Total additions (sum of line 4-9)		4,255,503		0		10.00
11.00	Subtotal (line 3 plus line 10)		55,295,124		0		11.00
12.00	TRANSFERS	0		0		0	12.00
13.00	RECONCILIING ITEM	0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		55,295,124		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	RECONCILING ITEM		0				4.00
5.00	GAINS ON INVESTMENTS		0				5.00
6.00	TEMPORARILY RESTRICTED		0				6.00
7.00	CONTRIBUTIONS		0				7.00
8.00	TRANSFERS		0				8.00
9.00	ASSETS RELEASED		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	TRANSFERS		0				12.00
13.00	RECONCILIING ITEM		0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0103

Period:
From 01/01/2019
To 12/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
6/24/2020 11:04 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	27,564,164		27,564,164	1.00
2.00	SUBPROVIDER - IPF	15,340,615		15,340,615	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)	42,904,779		42,904,779	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	6,353,546		6,353,546	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	6,353,546		6,353,546	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	49,258,325		49,258,325	17.00
18.00	Ancillary services	58,801,903	0	58,801,903	18.00
19.00	Outpatient services	0	70,124,692	70,124,692	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OP PHARMACY	404,100	1,519,224	1,923,324	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	108,464,328	71,643,916	180,108,244	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		101,717,133		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	BAD DEBTS	0			31.00
32.00	BP	0			32.00
33.00		0			33.00
34.00		0			34.00
35.00	ROUNDING	0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		101,717,133		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0103

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

Worksheet G-3

Date/Time Prepared:
6/24/2020 11:04 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	180,108,244	1.00
2.00	Less contractual allowances and discounts on patients' accounts	89,411,538	2.00
3.00	Net patient revenues (line 1 minus line 2)	90,696,706	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	101,717,133	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-11,020,427	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	114,695	7.00
8.00	Revenues from telephone and other miscellaneous communication services	2,337	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	494,557	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	23,466	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	26,724	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	95,747	24.00
24.01	ER PRO FEE INCOME	1,609,159	24.01
24.02	ANEST PRO FEE INCOME	761,113	24.02
24.03	SISTERS MAINTENANCE	0	24.03
24.04	OTHER RENTAL INCOME	307,175	24.04
24.05	OTHER	0	24.05
24.06	PARTNERS IN HEALTH	355,275	24.06
24.07	OTHER PRO FEE	2,400,909	24.07
24.08	CLINIC REVENUE	942,291	24.08
24.09	GAIN FROM DISPOSAL	63,079	24.09
24.10	NET ASSETS RELEASED	3,031,257	24.10
24.11	CAPITAL GAINS	125,245	24.11
25.00	Total other income (sum of lines 6-24)	10,353,029	25.00
26.00	Total (line 5 plus line 25)	-667,398	26.00
27.00	ROUNDING	-1	27.00
27.01	OTHER EXPENSES (SPECIFY)	0	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	-1	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-667,397	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0103	Period: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III Date/Time Prepared: 6/24/2020 11:04 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		463,334	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		5,937	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)		51.82	3.00
4.00	Number of interns & residents (see instructions)		3.03	4.00
5.00	Indirect medical education percentage (see instructions)		1.66	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)		7,691	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		25.49	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		62.25	8.00
9.00	Sum of lines 7 and 8		87.74	9.00
10.00	Allowable disproportionate share percentage (see instructions)		19.45	10.00
11.00	Disproportionate share adjustment (see instructions)		90,118	11.00
12.00	Total prospective capital payments (see instructions)		567,080	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