

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: 14-0127	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 7/30/2020 8:13 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 7/30/2020	Time: 8:13 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 ADVOCATE BROMENN MEDICAL CENTER (14-0127) 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) MICHAEL VOLANTE
Officer or Administrator of Provider(s)

VP REIMBURSEMENT
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	-31,155	46,517	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	22,873	0		0	3.00
4.00	SUBPROVIDER I						4.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	-8,282	46,517	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: 14-0127		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 7/30/2020 8:13 am		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1304 VIRGINIA			PO Box:				1.00		
2.00	City: NORMAL			State: IL		Zip Code: 61761-		County: MCLEAN 2.00		
		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		ADVOCATE BROMENN MEDICAL CENTER	140127	14060	1	07/01/1966	N	P O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF		ADVOCATE BROMENN REHABILITATION	14T127	14060	5	07/01/1990	N	P O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2019	12/31/2019		20.00	
21.00	Type of Control (see instructions)					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		Y	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.				1	N			23.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part I
Date/Time Prepared:
7/30/2020 8:13 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	
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.	0	1,781	0	0	4,700	122	24.00
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	124	0	0	69		25.00
					Urban/Rural S	Date of Geogr	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	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	Y	
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		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0127		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 7/30/2020 8:13 am	
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 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.	Y	Y			60.00	
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1		60.01	
		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	
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
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
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>							
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)					Y	63.00

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From 01/01/2019
To 12/31/2019Worksheet S-2
Part I
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			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)					64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	FAMILY PRACTICE - OSTEOPATHIC	3630	1.50	6.64	0.184275	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	FAMILY MEDICINE & OSTEOPATHIC MANIPU	3630	1.37	3.39	0.287815	67.00
67.01		FAMILY MEDICINE & OMT	6400	0.00	0.84	0.000000	67.01
67.02		FAMILY MEDICINE GENERAL	1350	0.00	0.42	0.000000	67.02

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			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00
			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.	Y	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)	N			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00

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				V	XIX		
				1.00	2.00		
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	N	109.00	
				1.00	2.00		
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	
				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		
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				0115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00	
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	103,738		1,376,899		436,014118.01	
				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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0127		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 7/30/2020 8:13 am	
		1.00		2.00			
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		14H036		140.00	
		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: ADVOCATE AURORA HEALTHCARE	Contractor's Name: NGS		Contractor's Number: 06101		141.00	
142.00	Street: 3075 HIGHLAND PKWY	PO Box: SUITE 600				142.00	
143.00	City: DOWNERS GROVE	State: IL		Zip Code: 60515		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.					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	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
161.10	CORF		N	N	N	161.10	
				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	
		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)			0.00		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0127	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 7/30/2020 8:13 am
			Beginning 1.00	Ending 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)	Y	4,556	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0127	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 7/30/2020 8:13 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	03/26/2020 4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N 16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	03/15/2020	Y 03/15/2020 17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N 18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N 19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part II
Date/Time Prepared:
7/30/2020 8:13 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?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PAMELA	DYE		41.00
42.00	Enter the employer/company name of the cost report preparer.	ADVOCATE HEALTHCARE			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	630-929-5760	PAMELA.DYE@ADVOCATEHEALTH.CO M		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part II
Date/Time Prepared:
7/30/2020 8:13 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.	SENIOR REIMBURSEMENT SPECIALIST		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: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
7/30/2020 8:13 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	158	57,670	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)		158	57,670	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	48	17,520	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)		206	75,190	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00 SUBPROVIDER - IRF	41.00	15	5,475		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	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	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
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)		221				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: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
7/30/2020 8:13 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)	5,327	720	14,624			1.00
2.00	HMO and other (see instructions)	4,556	4,700				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	299	69				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)	5,327	720	14,624			7.00
8.00	INTENSIVE CARE UNIT	5,221	350	13,516			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		711	3,803			13.00
14.00	Total (see instructions)	10,548	1,781	31,943	13.76	917.30	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF	1,365	124	2,569	0.00	14.25	17.00
18.00	SUBPROVIDER		0	0	0.00	0.00	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	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)			470			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
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)				13.76	931.55	27.00
28.00	Observation Bed Days		89	4,702			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			414			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	122	394			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			45			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: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
7/30/2020 8:13 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	2,504	294	7,854	1.00
2.00 HMO and other (see instructions)			1,079	1,260		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				6		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	2,504	294	7,854	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00 SUBPROVIDER - IRF	0.00	0	116	13	222	17.00
18.00 SUBPROVIDER	0.00	0		0	0	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	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00					25.10
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: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part II
Date/Time Prepared:
7/30/2020 8:13 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	61,802,533	0	61,802,533	1,937,624.00	31.90
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		236,093	0	236,093	1,656.00	142.57
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		14,580	0	14,580	69.00	211.30
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	1,645,253	0	1,645,253	52,853.00	31.13
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		2,314,356	-190,328	2,124,028	88,142.00	24.10
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		415,933	0	415,933	5,253.00	79.18
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		2,795,170	0	2,795,170	20,743.00	134.75
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		7,662,759	0	7,662,759	107,543.00	71.25
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)		16,723,918	0	16,723,918		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		636,824	0	636,824		
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		51,760	0	51,760		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		4,221	0	4,221		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		476,333	0	476,333		
25.50	Home office wage-related (core)		1,155,401	0	1,155,401		
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: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part II
Date/Time Prepared:
7/30/2020 8:13 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	1,570,136	-1,349,939	220,197	7,259.00	30.33	26.00
27.00	Administrative & General	5.00	6,497,254	1,242,749	7,740,003	201,783.00	38.36	27.00
28.00	Administrative & General under contract (see inst.)		832,170	0	832,170	5,782.00	143.92	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,626,699	-7,718	1,618,981	61,396.00	26.37	30.00
31.00	Laundry & Linen Service	8.00	426,851	-21,304	405,547	25,493.00	15.91	31.00
32.00	Housekeeping	9.00	1,362,270	6,440	1,368,710	85,966.00	15.92	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,212,207	-652,819	559,388	32,253.00	17.34	34.00
35.00	Dietary under contract (see instructions)		585	0	585	7.00	83.57	35.00
36.00	Cafeteria	11.00	0	660,092	660,092	36,720.00	17.98	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,968,483	0	1,968,483	49,504.00	39.76	38.00
39.00	Central Services and Supply	14.00	346,369	6,605	352,974	17,430.00	20.25	39.00
40.00	Pharmacy	15.00	2,362,662	16,917	2,379,579	48,500.00	49.06	40.00
41.00	Medical Records & Medical Records Library	16.00	1,278,343	8,143	1,286,486	44,990.00	28.59	41.00
42.00	Social Service	17.00	1,368,175	8,344	1,376,519	32,677.00	42.13	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part III
Date/Time Prepared:
7/30/2020 8:13 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)	60,975,455	0	60,975,455	1,890,491.00	32.25	1.00
2.00	Excluded area salaries (see instructions)	2,314,356	-190,328	2,124,028	88,142.00	24.10	2.00
3.00	Subtotal salaries (line 1 minus line 2)	58,661,099	190,328	58,851,427	1,802,349.00	32.65	3.00
4.00	Subtotal other wages & related costs (see inst.)	10,873,862	0	10,873,862	133,539.00	81.43	4.00
5.00	Subtotal wage-related costs (see inst.)	17,931,079	0	17,931,079	0.00	30.47	5.00
6.00	Total (sum of lines 3 thru 5)	87,466,040	190,328	87,656,368	1,935,888.00	45.28	6.00
7.00	Total overhead cost (see instructions)	20,852,204	-82,490	20,769,714	649,760.00	31.97	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part IV
Date/Time Prepared:
7/30/2020 8:13 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	1,429,102	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)	1,501,200	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	108,693	6.00
7.00	Employee Managed Care Program Administration Fees	753,692	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	5,259,266	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	1,621,984	9.00
10.00	Dental, Hearing and Vision Plan	265,437	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	58,998	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)	712,589	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	1,009,171	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	132,896	16.00
TAXES			
17.00	FICA-Employers Portion Only	4,343,632	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	49,820	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))	283,548	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	363,030	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	17,893,058	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS(SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part V
Date/Time Prepared:
7/30/2020 8:13 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	415,933	17,893,058	1.00
2.00	Hospital	415,933	16,723,918	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	262,030	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	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis			17.00
18.00	Other	0	907,110	18.00

Health Financial Systems		ADVOCATE BROMENN MEDICAL CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0127	Period: From 01/01/2019 To 12/31/2019	Worksheet S-10 Date/Time Prepared: 7/30/2020 8:13 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)			0.281356	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			14,609,982	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			75,107,972	6.00
7.00	Medicaid cost (line 1 times line 6)			21,132,079	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			6,522,097	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)			6,522,097	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	5,647,357	659,173	6,306,530	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,588,918	659,173	2,248,091	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)	1,588,918	659,173	2,248,091	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			7,021,535	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			555,317	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			854,334	27.01
28.00	Non-Medicare bad debt expense (see instructions)			6,167,201	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			2,034,196	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			4,282,287	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			10,804,384	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0127

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

Worksheet A

Date/Time Prepared:
7/30/2020 8:13 am

	Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 + -col. 4)	
			1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		6,146,241	6,146,241	0	6,146,241	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	4,044,486	4,044,486	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,570,136	13,767,674	15,337,810	-1,482,879	13,854,931	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,497,254	30,442,125	36,939,379	1,121,373	38,060,752	5.00
7.00	00700	OPERATION OF PLANT	1,626,699	4,767,487	6,394,186	-188,514	6,205,672	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	426,851	261,599	688,450	-58,780	629,670	8.00
9.00	00900	HOUSEKEEPING	1,362,270	605,361	1,967,631	-25,506	1,942,125	9.00
10.00	01000	DIETARY	1,212,207	710,189	1,922,396	-962,147	960,249	10.00
11.00	01100	CAFETERIA	0	0	0	949,333	949,333	11.00
13.00	01300	NURSING ADMINISTRATION	1,968,483	214,024	2,182,507	-15,994	2,166,513	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	346,369	815,707	1,162,076	-456,421	705,655	14.00
15.00	01500	PHARMACY	2,362,662	6,699,131	9,061,793	-251,719	8,810,074	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,278,343	594,944	1,873,287	8,129	1,881,416	16.00
17.00	01700	SOCIAL SERVICE	1,368,175	96,041	1,464,216	8,344	1,472,560	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,645,253	0	1,645,253	0	1,645,253	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	576,535	576,535	0	576,535	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	437,642	62,749	500,391	-228,619	271,772	23.00
23.01	02301	EMS PROGRAM	0	0	0	0	0	23.01
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	11,859,313	6,701,727	18,561,040	-7,325,490	11,235,550	30.00
31.00	03100	INTENSIVE CARE UNIT	6,018,674	1,967,651	7,986,325	249,654	8,235,979	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	913,099	173,558	1,086,657	-42,654	1,044,003	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	2,961,087	2,961,087	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,075,263	17,850,967	21,926,230	-13,185,179	8,741,051	50.00
51.00	05100	RECOVERY ROOM	569,937	91,258	661,195	-46,118	615,077	51.00
53.00	05300	ANESTHESIOLOGY	29,146	3,001,166	3,030,312	-298,105	2,732,207	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,116,650	1,940,892	4,057,542	-1,387,932	2,669,610	54.00
57.00	05700	CT SCAN	518,861	814,150	1,333,011	-629,965	703,046	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,265,334	3,399,213	5,664,547	-2,152,874	3,511,673	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,992,258	1,992,258	64.00
65.00	06500	RESPIRATORY THERAPY	892,853	326,431	1,219,284	-213,800	1,005,484	65.00
66.00	06600	PHYSICAL THERAPY	1,555,370	305,774	1,861,144	-14,451	1,846,693	66.00
67.00	06700	OCCUPATIONAL THERAPY	426,516	35,329	461,845	-4,045	457,800	67.00
68.00	06800	SPEECH PATHOLOGY	226,795	18,913	245,708	-1,097	244,611	68.00
69.00	06900	ELECTROCARDIOLOGY	2,276,343	4,080,589	6,356,932	-3,742,723	2,614,209	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	66,693	78,627	145,320	-8,961	136,359	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	12,121,927	12,121,927	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	10,332,309	10,332,309	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	338,233	47,856	386,089	-13,075	373,014	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	455,265	71,898	527,163	-9,046	518,117	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	497,090	54,125	551,215	-551,215	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	339,486	339,486	90.03
90.04	09003	WOUND CARE CLINIC	542,667	744,101	1,286,768	-334,245	952,523	90.04
91.00	09100	EMERGENCY	3,092,472	4,290,087	7,382,559	-498,268	6,884,291	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	1,771,371	1,771,371	0	1,771,371	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	60,838,918	113,525,490	174,364,408	-1,436	174,362,972	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	492,277	383,177	875,454	-1,779	873,675	190.00
190.01	19001	OTHER NONREIMBURSABLE	471,338	1,374,182	1,845,520	3,215	1,848,735	190.01
190.13	19007	EUREKA	0	0	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	61,802,533	115,282,849	177,085,382	0	177,085,382	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0127

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

Worksheet A

Date/Time Prepared:
7/30/2020 8:13 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-278,997	5,867,244	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,000,649	5,045,135	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-543,292	13,311,639	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-13,009,043	25,051,709	5.00
7.00	00700	OPERATION OF PLANT	358,042	6,563,714	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-230,340	399,330	8.00
9.00	00900	HOUSEKEEPING	-33,988	1,908,137	9.00
10.00	01000	DIETARY	48	960,297	10.00
11.00	01100	CAFETERIA	-227,593	721,740	11.00
13.00	01300	NURSING ADMINISTRATION	-47,253	2,119,260	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	705,655	14.00
15.00	01500	PHARMACY	-86,818	8,723,256	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,858	1,878,558	16.00
17.00	01700	SOCIAL SERVICE	0	1,472,560	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,645,253	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	57,263	633,798	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	-14,250	257,522	23.00
23.01	02301	EMS PROGRAM	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-3,739,569	7,495,981	30.00
31.00	03100	INTENSIVE CARE UNIT	-147,708	8,088,271	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	1,044,003	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	-612,811	2,348,276	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-3,059,072	5,681,979	50.00
51.00	05100	RECOVERY ROOM	0	615,077	51.00
53.00	05300	ANESTHESIOLOGY	-2,658,156	74,051	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	33,419	2,703,029	54.00
57.00	05700	CT SCAN	-122	702,924	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-316,743	3,194,930	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,992,258	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,005,484	65.00
66.00	06600	PHYSICAL THERAPY	-35,991	1,810,702	66.00
67.00	06700	OCCUPATIONAL THERAPY	32,201	490,001	67.00
68.00	06800	SPEECH PATHOLOGY	24,709	269,320	68.00
69.00	06900	ELECTROCARDIOLOGY	-7	2,614,202	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	136,359	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,121,927	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	10,332,309	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	373,014	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	112,014	630,131	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	339,486	90.03
90.04	09003	WOUND CARE CLINIC	81,374	1,033,897	90.04
91.00	09100	EMERGENCY	-3,221,962	3,662,329	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
113.00	11300	INTEREST EXPENSE	-1,771,371	0	113.00
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-28,338,225	146,024,747	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	873,675	190.00
190.01	19001	OTHER NONREIMBURSABLE	465,401	2,314,136	190.01
190.13	19007	EUREKA	0	0	190.13
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-27,872,824	149,212,558	200.00

RECLASSIFICATIONS

Provider CCN: 14-0127

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

Worksheet A-6

Date/Time Prepared:
7/30/2020 8:13 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - NURSERY EXPENSE					
1.00	NURSERY	43.00	2,295,332	990,570		1.00
	TOTALS		2,295,332	990,570		
	B - CAFETERIA EXPENSE					
1.00	CAFETERIA	11.00	656,237	289,241		1.00
	TOTALS		656,237	289,241		
	C - MEDICAL SUPPLY RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	22,454,236		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	4,341		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
	TOTALS		0	22,458,577		
	D - MANAGEMENT COMPENSATION RECLASS					
1.00		0.00	0	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	983,438	0		2.00
3.00	OPERATION OF PLANT	7.00	20,875	0		3.00
4.00	HOUSEKEEPING	9.00	6,440	0		4.00
5.00	DIETARY	10.00	3,418	0		5.00
6.00	CAFETERIA	11.00	3,855	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	6,605	0		7.00
8.00	PHARMACY	15.00	29,798	0		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	8,143	0		9.00
10.00	SOCIAL SERVICE	17.00	8,344	0		10.00
11.00	CLINICAL PASTORAL EDUCATION	23.00	5,974	0		11.00
12.00	ADULTS & PEDIATRICS	30.00	103,497	0		12.00
13.00	INTENSIVE CARE UNIT	31.00	16,643	0		13.00
14.00	SUBPROVIDER - IRF	41.00	9,206	0		14.00
15.00	NURSERY	43.00	5,043	0		15.00
16.00	OPERATING ROOM	50.00	37,072	0		16.00
17.00	RADIOLOGY-DIAGNOSTIC	54.00	16,571	0		17.00
18.00	LABORATORY	60.00	9,757	0		18.00
19.00	INTRAVENOUS THERAPY	64.00	15,619	0		19.00
20.00	PHYSICAL THERAPY	66.00	10,795	0		20.00
21.00	ELECTROCARDIOLOGY	69.00	32,168	0		21.00
22.00	EMERGENCY	91.00	9,645	0		22.00
23.00	OTHER NONREIMBURSABLE	190.01	7,033	0		23.00
	TOTALS		1,349,939	0		
	E - IMPLANT RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	10,332,309		1.00
	TOTALS		0	10,332,309		

RECLASSIFICATIONS

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet A-6
Date/Time Prepared:
7/30/2020 8:13 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	F - EQUIP DEPR EXPENSE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	4,058,059		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
	TOTALS		0	4,058,059		
	G - BASIC DIAGNOSTIC TESTING					
1.00	OPERATING ROOM	50.00	467,264	47,677		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	4,971	507		2.00
3.00	LABORATORY	60.00	14,913	1,522		3.00
4.00	ELECTROCARDIOLOGY	69.00	9,942	1,014		4.00
	TOTALS		497,090	50,720		
	H - RECLASS EUREKA ALLOCATED COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	80,770	151,831		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
	TOTALS		80,770	151,831		
	I - A&G RELATED CPE COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	212,541	18,284		1.00
	TOTALS		212,541	18,284		
	J - RECLASS MD CONTRACT EXPENSES					
1.00	ADULTS & PEDIATRICS	30.00	25,000	0		1.00
2.00	OPERATING ROOM	50.00	0	97,900		2.00
3.00	WOUND CARE CLINIC	90.04	9,000	0		3.00
	TOTALS		34,000	97,900		
	K - ASSOCIATE BONUS					
1.00		0.00	0	0		1.00
	TOTALS		0	0		
	L - INFUSION THERAPY					
1.00	INTRAVENOUS THERAPY	64.00	1,572,899	403,740		1.00
2.00		0.00	0	0		2.00
	TOTALS		1,572,899	403,740		
	M - OP BEHAVIORAL HEALTH					
1.00	PSYCH OUTPATIENT	90.03	314,806	24,680		1.00
	TOTALS		314,806	24,680		
	N - ICU RECLASS					
1.00	INTENSIVE CARE UNIT	31.00	1,377,699	127,865		1.00
	TOTALS		1,377,699	127,865		
500.00	Grand Total: Increases		8,391,313	39,003,776		500.00

RECLASSIFICATIONS

Provider CCN: 14-0127

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

Worksheet A-6

Date/Time Prepared:
7/30/2020 8:13 am

	Decreases							7/30/2020 8:13 am
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
	A - NURSERY EXPENSE							
1.00	ADULTS & PEDIATRICS	30.00	2,295,332	990,570	0			1.00
	TOTALS		2,295,332	990,570				
	B - CAFETERIA EXPENSE							
1.00	DIETARY	10.00	656,237	289,241	0			1.00
	TOTALS		656,237	289,241				
	C - MEDICAL SUPPLY RECLASS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5,134	0			1.00
2.00	OPERATION OF PLANT	7.00	0	83,914	0			2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	4,499	0			3.00
4.00	HOUSEKEEPING	9.00	0	8,685	0			4.00
5.00	DIETARY	10.00	0	2,775	0			5.00
6.00	NURSING ADMINISTRATION	13.00	0	2,173	0			6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	416,698	0			7.00
8.00	PHARMACY	15.00	0	84,519	0			8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	14	0			9.00
10.00	CLINICAL PASTORAL EDUCATION	23.00	0	3,768	0			10.00
11.00	ADULTS & PEDIATRICS	30.00	0	545,651	0			11.00
12.00	INTENSIVE CARE UNIT	31.00	0	465,262	0			12.00
13.00	SUBPROVIDER - IRF	41.00	0	36,793	0			13.00
14.00	NURSERY	43.00	0	200,897	0			14.00
15.00	OPERATING ROOM	50.00	0	13,178,710	0			15.00
16.00	RECOVERY ROOM	51.00	0	28,498	0			16.00
17.00	ANESTHESIOLOGY	53.00	0	264,336	0			17.00
18.00	RADIOLOGY-DIAGNOSTIC	54.00	0	409,508	0			18.00
19.00	CT SCAN	57.00	0	281,461	0			19.00
20.00	LABORATORY	60.00	0	2,035,800	0			20.00
21.00	RESPIRATORY THERAPY	65.00	0	141,093	0			21.00
22.00	PHYSICAL THERAPY	66.00	0	9,456	0			22.00
23.00	OCCUPATIONAL THERAPY	67.00	0	4,045	0			23.00
24.00	SPEECH PATHOLOGY	68.00	0	1,097	0			24.00
25.00	ELECTROCARDIOLOGY	69.00	0	3,517,774	0			25.00
26.00	ELECTROENCEPHALOGRAPHY	70.00	0	2,255	0			26.00
27.00	CARDIAC REHABILITATION	76.97	0	4,829	0			27.00
28.00	CLINIC	90.00	0	7,615	0			28.00
29.00	WOUND CARE CLINIC	90.04	0	342,431	0			29.00
30.00	EMERGENCY	91.00	0	362,202	0			30.00
31.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	70	0			31.00
32.00	BASIC DIAGNOSTIC TESTING	90.01	0	3,405	0			32.00
33.00	OTHER NONREIMBURSABLE	190.01	0	3,210	0			33.00
	TOTALS		0	22,458,577				
	D - MANAGEMENT COMPENSATION RECLASS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1,349,939	0	0			1.00
2.00		0.00	0	0	0			2.00
3.00		0.00	0	0	0			3.00
4.00		0.00	0	0	0			4.00
5.00		0.00	0	0	0			5.00
6.00		0.00	0	0	0			6.00
7.00		0.00	0	0	0			7.00
8.00		0.00	0	0	0			8.00
9.00		0.00	0	0	0			9.00
10.00		0.00	0	0	0			10.00
11.00		0.00	0	0	0			11.00
12.00		0.00	0	0	0			12.00
13.00		0.00	0	0	0			13.00
14.00		0.00	0	0	0			14.00
15.00		0.00	0	0	0			15.00
16.00		0.00	0	0	0			16.00
17.00		0.00	0	0	0			17.00
18.00		0.00	0	0	0			18.00
19.00		0.00	0	0	0			19.00
20.00		0.00	0	0	0			20.00
21.00		0.00	0	0	0			21.00
22.00		0.00	0	0	0			22.00
23.00		0.00	0	0	0			23.00
	TOTALS		1,349,939	0				
	E - IMPLANT RECLASS							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	10,332,309	0			1.00
	TOTALS		0	10,332,309				

RECLASSIFICATIONS

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet A-6
Date/Time Prepared:
7/30/2020 8:13 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	F - EQUIP DEPR EXPENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,604	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	197,932	0		2.00
3.00	OPERATION OF PLANT	7.00	0	96,882	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	19,921	0		4.00
5.00	HOUSEKEEPING	9.00	0	23,261	0		5.00
6.00	DIETARY	10.00	0	17,312	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	13,821	0		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	46,328	0		8.00
9.00	PHARMACY	15.00	0	184,117	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	302,979	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	0	305,057	0		11.00
12.00	SUBPROVIDER - IRF	41.00	0	15,067	0		12.00
13.00	NURSERY	43.00	0	128,961	0		13.00
14.00	OPERATING ROOM	50.00	0	656,382	0		14.00
15.00	RECOVERY ROOM	51.00	0	17,620	0		15.00
16.00	ANESTHESIOLOGY	53.00	0	33,769	0		16.00
17.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,000,473	0		17.00
18.00	CT SCAN	57.00	0	348,504	0		18.00
19.00	LABORATORY	60.00	0	125,274	0		19.00
20.00	RESPIRATORY THERAPY	65.00	0	72,707	0		20.00
21.00	PHYSICAL THERAPY	66.00	0	15,790	0		21.00
22.00	ELECTROCARDIOLOGY	69.00	0	268,073	0		22.00
23.00	ELECTROENCEPHALOGRAPHY	70.00	0	6,706	0		23.00
24.00	CARDIAC REHABILITATION	76.97	0	8,246	0		24.00
25.00	CLINIC	90.00	0	1,431	0		25.00
26.00	WOUND CARE CLINIC	90.04	0	814	0		26.00
27.00	EMERGENCY	91.00	0	145,711	0		27.00
28.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	1,709	0		28.00
29.00	OTHER NONREIMBURSABLE	190.01	0	608	0		29.00
	TOTALS		0	4,058,059			
	G - BASIC DIAGNOSTIC TESTING						
1.00	BASIC DIAGNOSTIC TESTING	90.01	497,090	50,720	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		497,090	50,720			
	H - RECLASS EUREKA ALLOCATED COSTS						
1.00		0.00	0	0	0		1.00
2.00	NEW CAP REL COSTS-MVBLE	2.00	0	13,573	9		2.00
3.00	EQUIP						
3.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	125,202	0		3.00
4.00	OPERATION OF PLANT	7.00	28,593	0	0		4.00
5.00	LAUNDRY & LINEN SERVICE	8.00	21,304	13,056	0		5.00
6.00	PHARMACY	15.00	12,881	0	0		6.00
7.00	LABORATORY	60.00	17,992	0	0		7.00
	TOTALS		80,770	151,831			
	I - A&G RELATED CPE COSTS						
1.00	CLINICAL PASTORAL EDUCATION	23.00	212,541	18,284	0		1.00
	TOTALS		212,541	18,284			
	J - RECLASS MD CONTRACT EXPENSES						
1.00	ADMINISTRATIVE & GENERAL	5.00	34,000	97,900	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		34,000	97,900			
	K - ASSOCIATE BONUS						
1.00		0.00	0	0	0		1.00
	TOTALS		0	0			
	L - INFUSION THERAPY						
1.00	ADULTS & PEDIATRICS	30.00	1,153,999	320,406	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	418,900	83,334	0		2.00
	TOTALS		1,572,899	403,740			
	M - OP BEHAVIORAL HEALTH						
1.00	ADULTS & PEDIATRICS	30.00	314,806	24,680	0		1.00
	TOTALS		314,806	24,680			
	N - ICU RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	1,377,699	127,865	0		1.00
	TOTALS		1,377,699	127,865			
500.00	Grand Total: Decreases		8,391,313	39,003,776			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part I
Date/Time Prepared:
7/30/2020 8:13 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	7,844,000	0	0	0	0	1.00	
2.00	Land Improvements	10,449,617	0	0	0	0	2.00	
3.00	Buildings and Fixtures	245,489,192	5,899,590	0	5,899,590	3,007	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	84,915,917	2,715,265	0	2,715,265	28,307,849	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	348,698,726	8,614,855	0	8,614,855	28,310,856	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	348,698,726	8,614,855	0	8,614,855	28,310,856	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	7,844,000	0				1.00	
2.00	Land Improvements	10,449,617	4,727,428				2.00	
3.00	Buildings and Fixtures	251,385,775	127,432,978				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	59,323,333	32,355,206				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	329,002,725	164,515,612				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	329,002,725	164,515,612				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part II
Date/Time Prepared:
7/30/2020 8:13 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	NEW CAP REL COSTS-BLDG & FIXT	6,146,241	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	6,146,241	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	6,146,241				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	6,146,241				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part III
Date/Time Prepared:
7/30/2020 8:13 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	NEW CAP REL COSTS-BLDG & FIXT	269,679,392	0	269,679,392	0.819687	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	59,323,332	0	59,323,332	0.180313	0	2.00
3.00	Total (sum of lines 1-2)	329,002,724	0	329,002,724	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	5,867,244	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	5,045,135	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	10,912,379	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	5,867,244	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	5,045,135	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	10,912,379	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0127

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

Worksheet A-8

Date/Time Prepared:
7/30/2020 8:13 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0 NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			0 NEW 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	-13,566,316			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	792,113			0	12.00
13.00	Laundry and linen service	B	-230,340	LAUNDRY & LINEN SERVICE	8.00	0	13.00
14.00	Cafeteria-employees and guests	B	-236,797	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	B	-86,765	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-2,851	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		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0 RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0 PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0 *** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0 NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0 NEW 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 OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)	B	-235,000	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0 SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0127

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

Worksheet A-8

Date/Time Prepared:
7/30/2020 8:13 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	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELLANEOUS INCOME	B	-24,981	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.03	MISCELLANEOUS INCOME	B	-120,898	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	MISCELLANEOUS INCOME	B	-20,116	OPERATION OF PLANT	7.00	0	33.04
33.08	MISCELLANEOUS INCOME	B	-42,048	HOUSEKEEPING	9.00	0	33.08
33.09	MISCELLANEOUS INCOME	B	-47,253	NURSING ADMINISTRATION	13.00	0	33.09
33.10	MISCELLANEOUS INCOME	B	-10,900	I&R SERVICES-OTHER PRGM	22.00	0	33.10
33.19	MISCELLANEOUS INCOME	B	-8,280	COSTS APPRVD			
33.20	MISCELLANEOUS INCOME	B	0	CLINICAL PASTORAL EDUCATION	23.00	0	33.19
33.21	MISCELLANEOUS INCOME	B	-12,811	NURSERY	43.00	0	33.21
33.22	MISCELLANEOUS INCOME	B	-20	CLINIC	90.00	0	33.22
33.24	MISCELLANEOUS INCOME	B	-2,500	CT SCAN	57.00	0	33.24
33.25	MISCELLANEOUS INCOME	B	-302,264	LABORATORY	60.00	0	33.25
33.28	MISCELLANEOUS INCOME	B	-69,592	PHYSICAL THERAPY	66.00	0	33.28
34.00	MISCELLANEOUS INCOME	B	-906	ADULTS & PEDIATRICS	30.00	0	34.00
35.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.00
35.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.01
35.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.02
35.03	INTEREST EXPENSE	A	-1,771,371	INTEREST EXPENSE	113.00	11	35.03
35.04	PA ASSESSMENT EXPENSE	A	-6,920,712	ADMINISTRATIVE & GENERAL	5.00	0	35.04
35.05	CONTRIBUTIONS	A	-20,550	ADMINISTRATIVE & GENERAL	5.00	0	35.05
35.06	SELF INSURANCE EXPENSE	A	-3,166,573	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.06
35.07	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.07
35.08	NON ALLOWABLE EXPENSES	A	-1,501,045	ADMINISTRATIVE & GENERAL	5.00	0	35.08
35.09	NON ALLOWABLE EXPENSES	A	-1,506	OPERATION OF PLANT	7.00	0	35.09
36.00	NON ALLOWABLE EXPENSES	A	48	DIETARY	10.00	0	36.00
36.01	NON ALLOWABLE EXPENSES	A	-53	PHARMACY	15.00	0	36.01
36.02	NON ALLOWABLE EXPENSES	A	-7	MEDICAL RECORDS & LIBRARY	16.00	0	36.02
36.03	NON ALLOWABLE EXPENSES	A	-1,250	I&R SERVICES-OTHER PRGM	22.00	0	36.03
36.04	NON ALLOWABLE EXPENSES	A	-5,970	COSTS APPRVD			
36.05	NON ALLOWABLE EXPENSES	A	-17,577	CLINICAL PASTORAL EDUCATION	23.00	0	36.04
36.06	NON ALLOWABLE EXPENSES	A	-3	ADULTS & PEDIATRICS	30.00	0	36.05
36.07	NON ALLOWABLE EXPENSES	A	-2,708	HOUSEKEEPING	9.00	0	36.06
36.09	NON ALLOWABLE EXPENSES	A	0	INTENSIVE CARE UNIT	31.00	0	36.07
36.10	NON ALLOWABLE EXPENSES	A	-202	OPERATING ROOM	50.00	0	36.09
36.11	NON ALLOWABLE EXPENSES	A	0	RADIOLOGY-DIAGNOSTIC	54.00	0	36.10
36.13	NON ALLOWABLE EXPENSES	A	-85	PHYSICAL THERAPY	66.00	0	36.11
36.14	NON ALLOWABLE EXPENSES	A	-7	ELECTROCARDIOLOGY	69.00	0	36.13
36.15	MARKETING OFFSET	A	-5,620	ADMINISTRATIVE & GENERAL	5.00	0	36.14
36.16	EUREKA UNDERALLOCATION	A	153,901	ADMINISTRATIVE & GENERAL	5.00	0	36.15
36.17	LOBBYING FEES	A	-271	ADMINISTRATIVE & GENERAL	5.00	0	36.16
36.18	NON ALLOWABLE EXPENSES	A	-2,800	WOUND CARE CLINIC	90.04	0	36.17
36.19	NON ALLOWABLE EXPENSES	A	-17,387	EMERGENCY	91.00	0	36.18
37.00	NON ALLOWABLE EXPENSES	A	0		0.00	0	36.19
38.00	NON ALLOWABLE EXPENSES	A	0		0.00	0	37.00
39.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	38.00
40.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	39.00
41.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	40.00
42.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	41.00
43.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	42.00
44.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.00
44.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.00
44.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.01
44.03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.02

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0127

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

Worksheet A-8

Date/Time Prepared:
7/30/2020 8:13 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	
44.04	ADJ BOOK TO MC DEPR	A	-359,439	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	44.04
44.05	ADJ BOOK TO MC DEPR	A	-3,112	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	44.05
45.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-27,872,824				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0127

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

Worksheet A-8-1

Date/Time Prepared:
7/30/2020 8:13 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	54.00	RADIOLOGY-DIAGNOSTIC	ADVANCED MRI	80,499	65,000	1.00
2.00	0.00			0	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	BUILDING RENTAL	91,765	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	BUILDING RENTAL	98,315	0	3.01
3.02	11.00	CAFETERIA	BUILDING RENTAL	9,204	0	3.02
3.03	22.00	I&R SERVICES-OTHER PRGM COST	BUILDING RENTAL	69,413	0	3.03
3.04	54.00	RADIOLOGY-DIAGNOSTIC	BUILDING RENTAL	70,753	52,833	3.04
3.05	57.00	CT SCAN	BUILDING RENTAL	73,755	20,178	3.05
3.06	60.00	LABORATORY	BUILDING RENTAL	29,621	44,100	3.06
3.07	66.00	PHYSICAL THERAPY	BUILDING RENTAL	184,151	150,465	3.07
3.08	67.00	OCCUPATIONAL THERAPY	BUILDING RENTAL	32,201	0	3.08
3.09	68.00	SPEECH PATHOLOGY	BUILDING RENTAL	24,709	0	3.09
3.10	90.00	CLINIC	BUILDING RENTAL	112,034	0	3.10
3.11	90.04	WOUND CARE CLINIC	BUILDING RENTAL	84,174	0	3.11
3.12	190.01	OTHER NONREIMBURSABLE	BUILDING RENTAL	465,401	0	3.12
3.13	7.00	OPERATION OF PLANT	BUILDING RENTAL	379,664	0	3.13
3.14	9.00	HOUSEKEEPING	BUILDING RENTAL	8,063	0	3.14
3.15	0.00			0	0	3.15
4.00	1.00	NEW CAP REL COSTS-BLDG & FIX	HOME OFFICE	80,442	0	4.00
4.01	2.00	NEW CAP REL COSTS-MVBLE EQUI	HOME OFFICE	1,003,761	0	4.01
4.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	2,556,497	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	9,834,100	14,163,833	4.03
4.04	0.00			0	0	4.04
4.05	0.00			0	0	4.05
5.00	0		0	15,288,522	14,496,409	5.00

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

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

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

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

6.00	C		0.00	ADVANCED MRI	42.80	6.00
7.00	B		0.00	ADVOCATE HEALTH	100.00	7.00
8.00			0.00		0.00	8.00
9.00	B		0.00	ADVOCATE HEALTH CARE	100.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-0127

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

Worksheet A-8-1

Date/Time Prepared:
7/30/2020 8:13 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	15,499	0		1.00
2.00	0	0		2.00
3.00	91,765	0		3.00
3.01	98,315	0		3.01
3.02	9,204	0		3.02
3.03	69,413	0		3.03
3.04	17,920	0		3.04
3.05	53,577	0		3.05
3.06	-14,479	0		3.06
3.07	33,686	0		3.07
3.08	32,201	0		3.08
3.09	24,709	0		3.09
3.10	112,034	0		3.10
3.11	84,174	0		3.11
3.12	465,401	0		3.12
3.13	379,664	0		3.13
3.14	8,063	0		3.14
3.15	0	0		3.15
4.00	80,442	9		4.00
4.01	1,003,761	9		4.01
4.02	2,556,497	0		4.02
4.03	-4,329,733	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
5.00	792,113			5.00

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

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

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

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

6.00	MRI SERVICES		6.00
7.00	SAME PARENT CO		7.00
8.00			8.00
9.00	HOME OFFICE		9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0127

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

Worksheet A-8-2

Date/Time Prepared:
7/30/2020 8:13 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	362,430	362,430	0	171,400	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	3,486,086	3,486,086	0	171,400	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	145,000	145,000	0	171,400	0	3.00
4.00	43.00	NURSERY	600,000	600,000	0	171,400	0	4.00
5.00	50.00	OPERATING ROOM	3,058,870	3,058,870	0	171,400	0	5.00
6.00	53.00	ANESTHESIOLOGY	2,658,156	2,658,156	0	171,400	0	6.00
7.00	57.00	CT SCAN	51,199	51,199	0	171,400	0	7.00
8.00	91.00	EMERGENCY	3,204,575	3,204,575	0	171,400	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			13,566,316	13,566,316	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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	43.00	NURSERY	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	6.00
7.00	57.00	CT SCAN	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	0.00		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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	362,430		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	3,486,086		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	145,000		3.00
4.00	43.00	NURSERY	0	0	0	600,000		4.00
5.00	50.00	OPERATING ROOM	0	0	0	3,058,870		5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	2,658,156		6.00
7.00	57.00	CT SCAN	0	0	0	51,199		7.00
8.00	91.00	EMERGENCY	0	0	0	3,204,575		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	13,566,316		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
7/30/2020 8:13 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	5,867,244	5,867,244			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	5,045,135		5,045,135		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	13,311,639	0	3,232	13,314,871	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	25,051,709	593,247	246,626	1,681,323	5.00
7.00	00700	OPERATION OF PLANT	6,563,714	1,411,152	120,233	350,043	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	399,330	119,505	31,841	87,684	8.00
9.00	00900	HOUSEKEEPING	1,908,137	85,664	28,868	295,932	9.00
10.00	01000	DIETARY	960,297	43,622	10,742	120,946	10.00
11.00	01100	CAFETERIA	721,740	71,970	12,680	142,720	11.00
13.00	01300	NURSING ADMINISTRATION	2,119,260	97,232	2,591	425,610	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	705,655	68,301	30,044	76,317	14.00
15.00	01500	PHARMACY	8,723,256	59,042	228,494	514,329	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,878,558	67,195	0	278,154	16.00
17.00	01700	SOCIAL SERVICE	1,472,560	14,545	0	297,620	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,645,253	0	0	355,723	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	633,798	0	0	0	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	257,522	19,466	0	49,961	23.00
23.01	02301	EMS PROGRAM	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,495,981	772,377	361,737	1,474,776	30.00
31.00	03100	INTENSIVE CARE UNIT	8,088,271	588,144	352,233	1,512,212	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	1,044,003	134,900	18,699	199,413	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	2,348,276	63,136	160,045	497,369	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,681,979	359,499	815,286	990,164	50.00
51.00	05100	RECOVERY ROOM	615,077	31,580	22,249	123,227	51.00
53.00	05300	ANESTHESIOLOGY	74,051	6,319	41,908	6,302	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,703,029	183,638	1,242,623	462,303	54.00
57.00	05700	CT SCAN	702,924	23,038	432,503	112,184	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	3,194,930	157,562	155,698	490,941	60.00
64.00	06400	INTRAVENOUS THERAPY	1,992,258	118,594	53,128	343,456	64.00
65.00	06500	RESPIRATORY THERAPY	1,005,484	59,114	90,231	193,046	65.00
66.00	06600	PHYSICAL THERAPY	1,810,702	16,878	19,596	338,624	66.00
67.00	06700	OCCUPATIONAL THERAPY	490,001	0	0	92,218	67.00
68.00	06800	SPEECH PATHOLOGY	269,320	0	0	49,036	68.00
69.00	06900	ELECTROCARDIOLOGY	2,614,202	127,974	332,954	501,277	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	136,359	11,823	8,322	14,420	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,121,927	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	10,332,309	0	25,609	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	373,014	32,868	10,234	73,130	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	630,131	0	1,776	98,434	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	339,486	78,410	383	68,065	90.03
90.04	09003	WOUND CARE CLINIC	1,033,897	4,350	1,010	117,331	90.04
91.00	09100	EMERGENCY	3,662,329	201,500	180,684	670,715	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	146,024,747	5,622,645	5,042,259	13,105,005	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	873,675	62,237	2,121	106,436	190.00
190.01	19001	OTHER NONREIMBURSABLE	2,314,136	182,362	755	103,430	190.01
190.13	19007	EUREKA	0	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	0	191.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
7/30/2020 8:13 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						0 200.00
201.00		Negative Cost Centers		0	0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	149,212,558	5,867,244	5,045,135	13,314,871	149,212,558	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
7/30/2020 8:13 am

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	27,572,905					5.00
7.00	00700	OPERATION OF PLANT	1,914,319	10,359,461				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	144,702	320,491	1,103,553			8.00
9.00	00900	HOUSEKEEPING	525,574	229,737	80,044	3,153,956		9.00
10.00	01000	DIETARY	257,416	116,986	2,265	2,512	1,514,786	10.00
11.00	01100	CAFETERIA	215,141	193,011	2,674	89,461	0	11.00
13.00	01300	NURSING ADMINISTRATION	599,491	260,759	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	199,548	183,170	0	85,594	0	14.00
15.00	01500	PHARMACY	2,159,126	158,339	0	87,402	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	504,109	180,205	0	3,315	0	16.00
17.00	01700	SOCIAL SERVICE	404,556	39,006	0	9,996	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	453,575	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	143,667	0	0	15,069	0	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	74,112	52,204	0	5,124	0	23.00
23.01	02301	EMS PROGRAM	0	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,290,542	2,071,378	280,202	1,179,525	743,059	30.00
31.00	03100	INTENSIVE CARE UNIT	2,389,371	1,577,297	194,230	48,071	648,471	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	316,671	361,778	20,409	49,930	123,256	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	695,632	169,321	4,956	50,884	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,778,718	964,112	147,475	459,363	0	50.00
51.00	05100	RECOVERY ROOM	179,558	84,693	12,552	49,930	0	51.00
53.00	05300	ANESTHESIOLOGY	29,146	16,945	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,040,809	492,484	55,940	99,859	0	54.00
57.00	05700	CT SCAN	288,027	61,784	27,880	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	906,511	422,553	267	99,859	0	60.00
64.00	06400	INTRAVENOUS THERAPY	568,378	318,047	1,547	172,192	0	64.00
65.00	06500	RESPIRATORY THERAPY	305,532	158,535	0	9,996	0	65.00
66.00	06600	PHYSICAL THERAPY	495,471	45,263	10,516	19,439	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	131,976	0	20	3,265	0	67.00
68.00	06800	SPEECH PATHOLOGY	72,164	0	0	1,155	0	68.00
69.00	06900	ELECTROCARDIOLOGY	810,689	343,204	43,004	59,926	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	38,745	31,707	1,713	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,747,753	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,347,902	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	110,901	88,147	410	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	165,552	0	348	20,946	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	110,243	210,282	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	262,172	11,666	8,235	69,520	0	90.04
91.00	09100	EMERGENCY	1,068,834	540,386	208,866	399,437	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,746,633	9,703,490	1,103,553	3,091,770	1,514,786	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	236,757	166,909	0	58,318	0	190.00
190.01	19001	OTHER NONREIMBURSABLE	589,515	489,062	0	3,868	0	190.01
190.13	19007	EUREKA	0	0	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	27,572,905	10,359,461	1,103,553	3,153,956	1,514,786	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
7/30/2020 8:13 am

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,449,397					11.00
13.00	01300	NURSING ADMINISTRATION	48,303	3,553,246				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	17,008	0	1,365,637			14.00
15.00	01500	PHARMACY	47,471		30,492	12,007,951		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	43,899	19,432	2,859	0	2,977,726	16.00
17.00	01700	SOCIAL SERVICE	31,884	126,159	149	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	51,571	0	24,950	0	0	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	9,620	0	3,929	16	0	23.00
23.01	02301	EMS PROGRAM	0	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	205,390	779,735	166,919	5,416	124,742	30.00
31.00	03100	INTENSIVE CARE UNIT	215,903	852,649	105,024	6,563	33,406	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	28,921	113,840	37,316	261	16,679	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	66,366	278,984	49,390	2,939	34,571	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	112,497	428,311	163,865	203,652	416,595	50.00
51.00	05100	RECOVERY ROOM	13,679	54,736	718	4,285	24,722	51.00
53.00	05300	ANESTHESIOLOGY	1,441	5,772	433	65,617	47,604	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	61,556	551	18,585	101,418	259,424	54.00
57.00	05700	CT SCAN	15,648	0	7,273	50,362	286,578	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	86,722	1,648	52,777	499	355,281	60.00
64.00	06400	INTRAVENOUS THERAPY	47,613	157,790	29,056	1,747	13,830	64.00
65.00	06500	RESPIRATORY THERAPY	29,307	240	22,759	7,650	24,459	65.00
66.00	06600	PHYSICAL THERAPY	38,257	5,178	4,329	380	41,562	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,832	0	185	0	9,655	67.00
68.00	06800	SPEECH PATHOLOGY	5,581	0	1,049	0	2,710	68.00
69.00	06900	ELECTROCARDIOLOGY	57,578	226,009	111,736	186,992	232,175	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,644	0	24	0	5,690	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,468	0	0	112	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	99	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,094,369	368,284	73.00
76.97	07697	CARDIAC REHABILITATION	11,081	0	11,154	19	7,121	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	15,668	13,230	5,604	10,877	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	10,330	0	2,655	0	0	90.03
90.04	09003	WOUND CARE CLINIC	15,140	17,683	7,244	5,809	60,454	90.04
91.00	09100	EMERGENCY	101,782	446,979	77,078	250,495	611,973	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,403,692	3,543,394	937,552	9,999,366	2,977,726	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	28,312	0	411,188	0	0	190.00
190.01	19001	OTHER NONREIMBURSABLE	17,393	9,852	16,897	2,008,585	0	190.01
190.13	19007	EUREKA	0	0	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,449,397	3,553,246	1,365,637	12,007,951	2,977,726	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
7/30/2020 8:13 am

Cost Center Description			INTERNS & RESIDENTS			CLINICAL PASTORAL EDUCATION	EMS PROGRAM	
			SOCIAL SERVICE	SERVICES-SALAR	SERVICES-OTHER			
				Y & FRINGES	PRGM COSTS			
			17.00	21.00	22.00	23.00	23.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	2,396,475					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	2,454,551				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0		869,055			22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	0			471,954		23.00
23.01	02301	EMS PROGRAM	0				0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,009,973	2,454,551	869,055	282,584	0	30.00
31.00	03100	INTENSIVE CARE UNIT	456,730	0	0	13,065	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	231,084	0	0	7,487	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	19,030	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	15,514	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	21,579	0	54.00
57.00	05700	CT SCAN	0	0	0	6,066	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	6,066	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	11,554	0	0	0	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	0	0	0	15,514	0	90.04
91.00	09100	EMERGENCY	668,104	0	0	95,418	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,396,475	2,454,551	869,055	463,293	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	OTHER NONREIMBURSABLE	0	0	0	8,661	0	190.01
190.13	19007	EUREKA	0	0	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
7/30/2020 8:13 am

Cost Center Description			INTERNS & RESIDENTS			CLINICAL PASTORAL EDUCATION	EMS PROGRAM	
			SOCIAL SERVICE	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS			
201.00		Negative Cost Centers	17.00	21.00	22.00	23.00	23.01	
			0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,396,475	2,454,551	869,055	471,954		0 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
7/30/2020 8:13 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	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				22.00
23.00	02300	CLINICAL PASTORAL EDUCATION				23.00
23.01	02301	EMS PROGRAM				23.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,567,942	-3,323,606	19,244,336	30.00
31.00	03100	INTENSIVE CARE UNIT	17,081,640	0	17,081,640	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	2,704,647	0	2,704,647	41.00
42.00	04200	SUBPROVIDER	0	0	0	42.00
43.00	04300	NURSERY	4,440,899	0	4,440,899	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,537,030	0	12,537,030	50.00
51.00	05100	RECOVERY ROOM	1,217,006	0	1,217,006	51.00
53.00	05300	ANESTHESIOLOGY	295,538	0	295,538	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,743,798	0	6,743,798	54.00
57.00	05700	CT SCAN	2,014,267	0	2,014,267	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	5,925,248	0	5,925,248	60.00
64.00	06400	INTRAVENOUS THERAPY	3,817,636	0	3,817,636	64.00
65.00	06500	RESPIRATORY THERAPY	1,906,353	0	1,906,353	65.00
66.00	06600	PHYSICAL THERAPY	2,846,195	0	2,846,195	66.00
67.00	06700	OCCUPATIONAL THERAPY	739,152	0	739,152	67.00
68.00	06800	SPEECH PATHOLOGY	401,015	0	401,015	68.00
69.00	06900	ELECTROCARDIOLOGY	5,653,786	0	5,653,786	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	250,447	0	250,447	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,884,260	0	14,884,260	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	12,705,919	0	12,705,919	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,462,653	0	9,462,653	73.00
76.97	07697	CARDIAC REHABILITATION	718,079	0	718,079	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	974,120	0	974,120	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	819,854	0	819,854	90.03
90.04	09003	WOUND CARE CLINIC	1,630,025	0	1,630,025	90.04
91.00	09100	EMERGENCY	9,184,580	0	9,184,580	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	141,522,089	-3,323,606	138,198,483	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,945,953	0	1,945,953	190.00
190.01	19001	OTHER NONREIMBURSABLE	5,744,516	0	5,744,516	190.01
190.13	19007	EUREKA	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
200.00		Cross Foot Adjustments	0	0	0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
7/30/2020 8:13 am

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
201.00	Negative Cost Centers	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	149,212,558	-3,323,606	145,888,952		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
7/30/2020 8:13 am

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	NEW MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	3,232	3,232	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,577	593,247	246,626	857,450	5.00
7.00	00700	OPERATION OF PLANT	1,381	1,411,152	120,233	1,532,766	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	25,318	119,505	31,841	176,664	8.00
9.00	00900	HOUSEKEEPING	0	85,664	28,868	114,532	9.00
10.00	01000	DIETARY	10,194	43,622	10,742	64,558	10.00
11.00	01100	CAFETERIA	0	71,970	12,680	84,650	11.00
13.00	01300	NURSING ADMINISTRATION	62	97,232	2,591	99,885	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	68,301	30,044	98,345	14.00
15.00	01500	PHARMACY	25	59,042	228,494	287,561	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	90,496	67,195	0	157,691	16.00
17.00	01700	SOCIAL SERVICE	0	14,545	0	14,545	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	63,053	0	0	63,053	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	0	19,466	0	19,466	23.00
23.01	02301	EMS PROGRAM	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	122,898	772,377	361,737	1,257,012	30.00
31.00	03100	INTENSIVE CARE UNIT	234,628	588,144	352,233	1,175,005	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	30,182	134,900	18,699	183,781	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	63,136	160,045	223,181	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	215,275	359,499	815,286	1,390,060	50.00
51.00	05100	RECOVERY ROOM	0	31,580	22,249	53,829	51.00
53.00	05300	ANESTHESIOLOGY	0	6,319	41,908	48,227	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	122,893	183,638	1,242,623	1,549,154	54.00
57.00	05700	CT SCAN	20,178	23,038	432,503	475,719	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	56,197	157,562	155,698	369,457	60.00
64.00	06400	INTRAVENOUS THERAPY	0	118,594	53,128	171,722	64.00
65.00	06500	RESPIRATORY THERAPY	8,279	59,114	90,231	157,624	65.00
66.00	06600	PHYSICAL THERAPY	158,718	16,878	19,596	195,192	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	53	127,974	332,954	460,981	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	11,823	8,322	20,145	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	25,609	25,609	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	32,868	10,234	43,102	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	1,776	1,776	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	78,410	383	78,793	90.03
90.04	09003	WOUND CARE CLINIC	0	4,350	1,010	5,360	90.04
91.00	09100	EMERGENCY	0	201,500	180,684	382,184	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,177,407	5,622,645	5,042,259	11,842,311	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	62,237	2,121	64,358	190.00
190.01	19001	OTHER NONREIMBURSABLE	70	182,362	755	183,187	190.01
190.13	19007	EUREKA	0	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
7/30/2020 8:13 am

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	1,177,477	5,867,244	5,045,135	12,089,856	3,232	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
7/30/2020 8:13 am

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	857,883					5.00
7.00	00700	OPERATION OF PLANT	59,564	1,592,414				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,502	49,265	230,452			8.00
9.00	00900	HOUSEKEEPING	16,353	35,314	16,715	182,985		9.00
10.00	01000	DIETARY	8,009	17,983	473	146	91,198	10.00
11.00	01100	CAFETERIA	6,694	29,669	558	5,190	0	11.00
13.00	01300	NURSING ADMINISTRATION	18,653	40,083	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,209	28,156	0	4,966	0	14.00
15.00	01500	PHARMACY	67,181	24,339	0	5,071	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,685	27,700	0	192	0	16.00
17.00	01700	SOCIAL SERVICE	12,588	5,996	0	580	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	14,113	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	4,470	0	0	874	0	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	2,306	8,025	0	297	0	23.00
23.01	02301	EMS PROGRAM	0	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	71,270	318,401	58,514	68,435	44,736	30.00
31.00	03100	INTENSIVE CARE UNIT	74,345	242,456	40,560	2,789	39,041	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	9,853	55,611	4,262	2,897	7,421	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	21,644	26,027	1,035	2,952	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	55,344	148,199	30,797	26,651	0	50.00
51.00	05100	RECOVERY ROOM	5,587	13,019	2,621	2,897	0	51.00
53.00	05300	ANESTHESIOLOGY	907	2,605	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	32,385	75,703	11,682	5,794	0	54.00
57.00	05700	CT SCAN	8,962	9,497	5,822	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	28,206	64,953	56	5,794	0	60.00
64.00	06400	INTRAVENOUS THERAPY	17,685	48,889	323	9,990	0	64.00
65.00	06500	RESPIRATORY THERAPY	9,507	24,369	0	580	0	65.00
66.00	06600	PHYSICAL THERAPY	15,416	6,958	2,196	1,128	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,106	0	4	189	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,245	0	0	67	0	68.00
69.00	06900	ELECTROCARDIOLOGY	25,224	52,756	8,980	3,477	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,206	4,874	358	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	85,454	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	73,054	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	3,451	13,550	86	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	5,151	0	73	1,215	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	3,430	32,324	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	8,157	1,793	1,720	4,033	0	90.04
91.00	09100	EMERGENCY	33,257	83,066	43,617	23,174	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	832,173	1,491,580	230,452	179,378	91,198	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,367	25,657	0	3,383	0	190.00
190.01	19001	OTHER NONREIMBURSABLE	18,343	75,177	0	224	0	190.01
190.13	19007	EUREKA	0	0	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	857,883	1,592,414	230,452	182,985	91,198	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
7/30/2020 8:13 am

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	126,795					11.00
13.00	01300	NURSING ADMINISTRATION	4,226	162,949				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,488	0	139,182			14.00
15.00	01500	PHARMACY	4,153	0	3,108	391,537		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,840	891	291	0	206,357	16.00
17.00	01700	SOCIAL SERVICE	2,789	5,786	15	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	4,511	0	2,543	0	0	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	842	0	400	1	0	23.00
23.01	02301	EMS PROGRAM	0	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,968	35,758	17,012	177	8,645	30.00
31.00	03100	INTENSIVE CARE UNIT	18,886	39,101	10,704	214	2,315	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	2,530	5,221	3,803	8	1,156	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	5,806	12,794	5,034	96	2,396	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,841	19,642	16,701	6,640	28,870	50.00
51.00	05100	RECOVERY ROOM	1,197	2,510	73	140	1,713	51.00
53.00	05300	ANESTHESIOLOGY	126	265	44	2,140	3,299	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,385	25	1,894	3,307	17,978	54.00
57.00	05700	CT SCAN	1,369	0	741	1,642	19,860	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	7,587	76	5,379	16	24,621	60.00
64.00	06400	INTRAVENOUS THERAPY	4,165	7,236	2,961	57	958	64.00
65.00	06500	RESPIRATORY THERAPY	2,564	11	2,320	249	1,695	65.00
66.00	06600	PHYSICAL THERAPY	3,347	237	441	12	2,880	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,035	0	19	0	669	67.00
68.00	06800	SPEECH PATHOLOGY	488	0	107	0	188	68.00
69.00	06900	ELECTROCARDIOLOGY	5,037	10,365	11,388	6,097	16,090	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	144	0	2	0	394	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	663	0	0	8	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	7	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	296,535	25,522	73.00
76.97	07697	CARDIAC REHABILITATION	969	0	1,137	1	493	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,371	607	571	355	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	904	0	271	0	0	90.03
90.04	09003	WOUND CARE CLINIC	1,324	811	738	189	4,190	90.04
91.00	09100	EMERGENCY	8,904	20,498	7,856	8,168	42,410	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	122,796	162,497	95,553	326,044	206,357	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,477	0	41,907	0	0	190.00
190.01	19001	OTHER NONREIMBURSABLE	1,522	452	1,722	65,493	0	190.01
190.13	19007	EUREKA	0	0	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	126,795	162,949	139,182	391,537	206,357	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
7/30/2020 8:13 am

Cost Center Description			INTERNS & RESIDENTS			CLINICAL PASTORAL EDUCATION	EMS PROGRAM	
			SOCIAL SERVICE	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS			
				17.00	21.00			
						23.00	23.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	42,371					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	14,199				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0		75,451			22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	0			31,349		23.00
23.01	02301	EMS PROGRAM	0				0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,858					30.00
31.00	03100	INTENSIVE CARE UNIT	8,075					31.00
40.00	04000	SUBPROVIDER - IPF	0					40.00
41.00	04100	SUBPROVIDER - IRF	4,086					41.00
42.00	04200	SUBPROVIDER	0					42.00
43.00	04300	NURSERY	336					43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0					50.00
51.00	05100	RECOVERY ROOM	0					51.00
53.00	05300	ANESTHESIOLOGY	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0					54.00
57.00	05700	CT SCAN	0					57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0					58.00
59.00	05900	CARDIAC CATHETERIZATION	0					59.00
60.00	06000	LABORATORY	0					60.00
64.00	06400	INTRAVENOUS THERAPY	0					64.00
65.00	06500	RESPIRATORY THERAPY	0					65.00
66.00	06600	PHYSICAL THERAPY	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0					67.00
68.00	06800	SPEECH PATHOLOGY	0					68.00
69.00	06900	ELECTROCARDIOLOGY	0					69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0					70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0					73.00
76.97	07697	CARDIAC REHABILITATION	0					76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	204					90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0					90.01
90.03	09002	PSYCH OUTPATIENT	0					90.03
90.04	09003	WOUND CARE CLINIC	0					90.04
91.00	09100	EMERGENCY	11,812					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0					93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0					99.10
101.00	10100	HOME HEALTH AGENCY	0					101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0					109.00
110.00	11000	INTESTINAL ACQUISITION	0					110.00
111.00	11100	ISLET ACQUISITION	0					111.00
113.00	11300	INTEREST EXPENSE	0					113.00
116.00	11600	HOSPICE	0					116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	42,371	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190.00
190.01	19001	OTHER NONREIMBURSABLE	0					190.01
190.13	19007	EUREKA	0					190.13
191.00	19100	RESEARCH	0					191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0					192.00
200.00		Cross Foot Adjustments		14,199	75,451	31,349	0	200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0127

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

 Worksheet B
 Part II
 Date/Time Prepared:
 7/30/2020 8:13 am

Cost Center Description			INTERNS & RESIDENTS			CLINICAL PASTORAL EDUCATION	EMS PROGRAM	
			SOCIAL SERVICE	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS			
			17.00	21.00	22.00	23.00	23.01	
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	42,371	14,199	75,451	31,349	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
7/30/2020 8:13 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	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				22.00
23.00	02300	CLINICAL PASTORAL EDUCATION				23.00
23.01	02301	EMS PROGRAM				23.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,916,141	0	1,916,141	30.00
31.00	03100	INTENSIVE CARE UNIT	1,653,855	0	1,653,855	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	280,677	0	280,677	41.00
42.00	04200	SUBPROVIDER	0	0	0	42.00
43.00	04300	NURSERY	301,421	0	301,421	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,732,983	0	1,732,983	50.00
51.00	05100	RECOVERY ROOM	83,616	0	83,616	51.00
53.00	05300	ANESTHESIOLOGY	57,615	0	57,615	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,703,418	0	1,703,418	54.00
57.00	05700	CT SCAN	523,639	0	523,639	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	506,263	0	506,263	60.00
64.00	06400	INTRAVENOUS THERAPY	264,069	0	264,069	64.00
65.00	06500	RESPIRATORY THERAPY	198,965	0	198,965	65.00
66.00	06600	PHYSICAL THERAPY	227,888	0	227,888	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,044	0	6,044	67.00
68.00	06800	SPEECH PATHOLOGY	3,107	0	3,107	68.00
69.00	06900	ELECTROCARDIOLOGY	600,516	0	600,516	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	27,126	0	27,126	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	86,125	0	86,125	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	98,670	0	98,670	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	322,057	0	322,057	73.00
76.97	07697	CARDIAC REHABILITATION	62,807	0	62,807	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	11,347	0	11,347	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	115,738	0	115,738	90.03
90.04	09003	WOUND CARE CLINIC	28,343	0	28,343	90.04
91.00	09100	EMERGENCY	665,107	0	665,107	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,477,537	0	11,477,537	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	145,175	0	145,175	190.00
190.01	19001	OTHER NONREIMBURSABLE	346,145	0	346,145	190.01
190.13	19007	EUREKA	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
200.00		Cross Foot Adjustments	120,999	0	120,999	200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
7/30/2020 8:13 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	12,089,856	0	12,089,856		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0127

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

Worksheet B-1

Date/Time Prepared:
7/30/2020 8:13 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	482,862					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		4,065,291				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,604	61,582,338			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	48,823	198,727	7,776,131	-27,572,905	121,639,653	5.00
7.00	00700	OPERATION OF PLANT	116,135	96,882	1,618,981	0	8,445,142	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,835	25,657	405,547	0	638,360	8.00
9.00	00900	HOUSEKEEPING	7,050	23,261	1,368,710	0	2,318,601	9.00
10.00	01000	DIETARY	3,590	8,656	559,388	0	1,135,607	10.00
11.00	01100	CAFETERIA	5,923	10,217	660,092	0	949,110	11.00
13.00	01300	NURSING ADMINISTRATION	8,002	2,088	1,968,483	0	2,644,693	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,621	24,209	352,974	0	880,317	14.00
15.00	01500	PHARMACY	4,859	184,117	2,378,818	0	9,525,121	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,530	0	1,286,486	0	2,223,907	16.00
17.00	01700	SOCIAL SERVICE	1,197	0	1,376,519	0	1,784,725	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	1,645,253	0	2,000,976	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	633,798	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	1,602	0	231,075	0	326,949	23.00
23.01	02301	EMS PROGRAM	0	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	63,565	291,482	6,820,974	0	10,104,871	30.00
31.00	03100	INTENSIVE CARE UNIT	48,403	283,824	6,994,117	0	10,540,860	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	11,102	15,067	922,305	0	1,397,015	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	5,196	128,962	2,300,375	0	3,068,826	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	29,586	656,945	4,579,600	0	7,846,928	50.00
51.00	05100	RECOVERY ROOM	2,599	17,928	569,937	0	792,133	51.00
53.00	05300	ANESTHESIOLOGY	520	33,769	29,146	0	128,580	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,113	1,001,287	2,138,192	0	4,591,593	54.00
57.00	05700	CT SCAN	1,896	348,504	518,861	0	1,270,649	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	12,967	125,459	2,270,646	0	3,999,131	60.00
64.00	06400	INTRAVENOUS THERAPY	9,760	42,810	1,588,517	0	2,507,436	64.00
65.00	06500	RESPIRATORY THERAPY	4,865	72,707	892,853	0	1,347,875	65.00
66.00	06600	PHYSICAL THERAPY	1,389	15,790	1,566,165	0	2,185,800	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	426,516	0	582,219	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	226,795	0	318,356	68.00
69.00	06900	ELECTROCARDIOLOGY	10,532	268,289	2,318,453	0	3,576,407	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	973	6,706	66,693	0	170,924	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	12,121,927	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	20,635	0	0	10,357,918	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	2,705	8,246	338,233	0	489,246	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,431	455,265	0	730,341	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	6,453	309	314,806	0	486,344	90.03
90.04	09003	WOUND CARE CLINIC	358	814	542,667	0	1,156,588	90.04
91.00	09100	EMERGENCY	16,583	145,592	3,102,117	0	4,715,228	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	462,732	4,062,974	60,611,690	-27,572,905	117,994,501	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,122	1,709	492,277	0	1,044,469	190.00
190.01	19001	OTHER NONREIMBURSABLE	15,008	608	478,371	0	2,600,683	190.01
190.13	19007	EUREKA	0	0	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	0	0	191.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0127

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

Worksheet B-1

Date/Time Prepared:
7/30/2020 8:13 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,867,244	5,045,135	13,314,871		27,572,905	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.150975	1.241027	0.216212		0.226677	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			3,232		857,883	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000052		0.007053	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: 14-0127

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

Worksheet B-1

Date/Time Prepared:
7/30/2020 8:13 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	317,904				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,835	957,786			8.00
9.00	00900	HOUSEKEEPING	7,050	69,471	62,789		9.00
10.00	01000	DIETARY	3,590	1,966	50	33,502	10.00
11.00	01100	CAFETERIA	5,923	2,321	1,781	0	71,415 11.00
13.00	01300	NURSING ADMINISTRATION	8,002	0	0	0	2,380 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,621	0	1,704	0	838 14.00
15.00	01500	PHARMACY	4,859	0	1,740	0	2,339 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,530	0	66	0	2,163 16.00
17.00	01700	SOCIAL SERVICE	1,197	0	199	0	1,571 17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	300	0	2,541 22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	1,602	0	102	0	474 23.00
23.01	02301	EMS PROGRAM	0	0	0	0	0 23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	63,565	243,191	23,482	16,434	10,120 30.00
31.00	03100	INTENSIVE CARE UNIT	48,403	168,574	957	14,342	10,638 31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0 40.00
41.00	04100	SUBPROVIDER - IRF	11,102	17,713	994	2,726	1,425 41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0 42.00
43.00	04300	NURSERY	5,196	4,301	1,013	0	3,270 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	29,586	127,995	9,145	0	5,543 50.00
51.00	05100	RECOVERY ROOM	2,599	10,894	994	0	674 51.00
53.00	05300	ANESTHESIOLOGY	520	0	0	0	71 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,113	48,551	1,988	0	3,033 54.00
57.00	05700	CT SCAN	1,896	24,197	0	0	771 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00	06000	LABORATORY	12,967	232	1,988	0	4,273 60.00
64.00	06400	INTRAVENOUS THERAPY	9,760	1,343	3,428	0	2,346 64.00
65.00	06500	RESPIRATORY THERAPY	4,865	0	199	0	1,444 65.00
66.00	06600	PHYSICAL THERAPY	1,389	9,127	387	0	1,885 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	17	65	0	583 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	23	0	275 68.00
69.00	06900	ELECTROCARDIOLOGY	10,532	37,324	1,193	0	2,837 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	973	1,487	0	0	81 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.97	07697	CARDIAC REHABILITATION	2,705	356	0	0	546 76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	302	417	0	772 90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0 90.01
90.03	09002	PSYCH OUTPATIENT	6,453	0	0	0	509 90.03
90.04	09003	WOUND CARE CLINIC	358	7,147	1,384	0	746 90.04
91.00	09100	EMERGENCY	16,583	181,277	7,952	0	5,015 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0 93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0 99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0 109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0 111.00
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0	0	0 116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	297,774	957,786	61,551	33,502	69,163 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,122	0	1,161	0	1,395 190.00
190.01	19001	OTHER NONREIMBURSABLE	15,008	0	77	0	857 190.01
190.13	19007	EUREKA	0	0	0	0	0 190.13
191.00	19100	RESEARCH	0	0	0	0	0 191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0127

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

Worksheet B-1

Date/Time Prepared:
7/30/2020 8:13 am

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	10,359,461	1,103,553	3,153,956	1,514,786	1,449,397	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	32.586759	1.152192	50.231028	45.214793	20.295414	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,592,414	230,452	182,985	91,198	126,795	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.009103	0.240609	2.914284	2.722166	1.775467	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: 14-0127

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

Worksheet B-1

Date/Time Prepared:
7/30/2020 8:13 am

Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY (COSTED REQUISITIO)	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			(NURSING FTE'S)	(COSTED REQUIS.)		(TIME SPENT)	(TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	916,088					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	924,256				14.00
15.00	01500	PHARMACY	0	20,637	7,464,916			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,010	1,935	0	3,792,506		16.00
17.00	01700	SOCIAL SERVICE	32,526	101	0	0	3,526	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	16,886	0	0	0	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	0	2,659	10	0	0	23.00
23.01	02301	EMS PROGRAM	0	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	201,029	112,970	3,367	158,874	1,486	30.00
31.00	03100	INTENSIVE CARE UNIT	219,827	71,080	4,080	42,547	672	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	29,350	25,255	162	21,243	340	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	71,927	33,427	1,827	44,031	28	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	110,426	110,903	126,603	530,586	0	50.00
51.00	05100	RECOVERY ROOM	14,112	486	2,664	31,486	0	51.00
53.00	05300	ANESTHESIOLOGY	1,488	293	40,792	60,629	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	142	12,578	63,048	330,409	0	54.00
57.00	05700	CT SCAN	0	4,922	31,308	364,993	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	425	35,719	310	452,494	0	60.00
64.00	06400	INTRAVENOUS THERAPY	40,681	19,665	1,086	17,614	0	64.00
65.00	06500	RESPIRATORY THERAPY	62	15,403	4,756	31,152	0	65.00
66.00	06600	PHYSICAL THERAPY	1,335	2,930	236	52,935	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	125	0	12,297	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	710	0	3,451	0	68.00
69.00	06900	ELECTROCARDIOLOGY	58,269	75,622	116,246	295,704	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	16	0	7,247	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,730	0	0	143	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	126	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	5,653,646	469,056	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	7,549	12	9,069	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,411	3,793	6,762	0	17	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	1,797	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	4,559	4,903	3,611	76,996	0	90.04
91.00	09100	EMERGENCY	115,239	52,166	155,724	779,424	983	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	913,548	634,530	6,216,250	3,792,506	3,526	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	278,290	0	0	0	190.00
190.01	19001	OTHER NONREIMBURSABLE	2,540	11,436	1,248,666	0	0	190.01
190.13	19007	EUREKA	0	0	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0127

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

Worksheet B-1

Date/Time Prepared:
7/30/2020 8:13 am

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY (COSTED REQUISITIO)	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		(NURSING FTE'S)	(COSTED REQUIS.)		(TIME SPENT)	(TIME SPENT)	
201.00	Negative Cost Centers	13.00	14.00	15.00	16.00	17.00	201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	3,553,246	1,365,637	12,007,951	2,977,726	2,396,475	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	3.878717	1.477553	1.608585	0.785161	679.658253	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	162,949	139,182	391,537	206,357	42,371	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.177875	0.150588	0.052450	0.054412	12.016733	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: 14-0127

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

Worksheet B-1

Date/Time Prepared:
7/30/2020 8:13 am

Cost Center Description			INTERNS & RESIDENTS		CLINICAL PASTORAL EDUCATION (ASSIGNED TIME)	EMS PROGRAM (ASSIGNED TIME)		
			SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)				
			21.00	22.00				
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	100					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		100				22.00
23.00	02300	CLINICAL PASTORAL EDUCATION			80,375			23.00
23.01	02301	EMS PROGRAM				0		23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	100	100	48,125	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	2,225	0		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0	1,275	0		41.00
42.00	04200	SUBPROVIDER	0	0	0	0		42.00
43.00	04300	NURSERY	0	0	0	0		43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	2,642	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	3,675	0		54.00
57.00	05700	CT SCAN	0	0	1,033	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	1,033	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
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	BASIC DIAGNOSTIC TESTING	0	0	0	0		90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	0		90.03
90.04	09003	WOUND CARE CLINIC	0	0	2,642	0		90.04
91.00	09100	EMERGENCY	0	0	16,250	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0		93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0		111.00
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE			0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	100	78,900	0		118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
190.01	19001	OTHER NONREIMBURSABLE	0	0	1,475	0		190.01
190.13	19007	EUREKA	0	0	0	0		190.13
191.00	19100	RESEARCH	0	0	0	0		191.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0127

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

Worksheet B-1

Date/Time Prepared:
7/30/2020 8:13 am

Cost Center Description			INTERNS & RESIDENTS		CLINICAL PASTORAL EDUCATION (ASSIGNED TIME)	EMS PROGRAM (ASSIGNED TIME)		
			SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)				
			21.00	22.00	23.00	23.01		
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,454,551	869,055	471,954	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24,545.510000	8,690.550000	5.871900	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	14,199	75,451	31,349	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	141.990000	754.510000	0.390034	0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			0	0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			0.000000	0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
7/30/2020 8:13 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	19,244,336		19,244,336	0	19,244,336	30.00
31.00	03100	INTENSIVE CARE UNIT	17,081,640		17,081,640	0	17,081,640	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	2,704,647		2,704,647	0	2,704,647	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	4,440,899		4,440,899	0	4,440,899	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,537,030		12,537,030	0	12,537,030	50.00
51.00	05100	RECOVERY ROOM	1,217,006		1,217,006	0	1,217,006	51.00
53.00	05300	ANESTHESIOLOGY	295,538		295,538	0	295,538	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,743,798		6,743,798	0	6,743,798	54.00
57.00	05700	CT SCAN	2,014,267		2,014,267	0	2,014,267	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	5,925,248		5,925,248	0	5,925,248	60.00
64.00	06400	INTRAVENOUS THERAPY	3,817,636		3,817,636	0	3,817,636	64.00
65.00	06500	RESPIRATORY THERAPY	1,906,353	0	1,906,353	0	1,906,353	65.00
66.00	06600	PHYSICAL THERAPY	2,846,195	0	2,846,195	0	2,846,195	66.00
67.00	06700	OCCUPATIONAL THERAPY	739,152	0	739,152	0	739,152	67.00
68.00	06800	SPEECH PATHOLOGY	401,015	0	401,015	0	401,015	68.00
69.00	06900	ELECTROCARDIOLOGY	5,653,786		5,653,786	0	5,653,786	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	250,447		250,447	0	250,447	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,884,260		14,884,260	0	14,884,260	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	12,705,919		12,705,919	0	12,705,919	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,462,653		9,462,653	0	9,462,653	73.00
76.97	07697	CARDIAC REHABILITATION	718,079		718,079	0	718,079	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	974,120		974,120	0	974,120	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0		0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	819,854		819,854	0	819,854	90.03
90.04	09003	WOUND CARE CLINIC	1,630,025		1,630,025	0	1,630,025	90.04
91.00	09100	EMERGENCY	9,184,580		9,184,580	0	9,184,580	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,682,111		4,682,111	0	4,682,111	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0		0		0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0		0	110.00
111.00	11100	ISLET ACQUISITION	0		0		0	111.00
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	142,880,594	0	142,880,594	0	142,880,594	200.00
201.00		Less Observation Beds	4,682,111		4,682,111		4,682,111	201.00
202.00		Total (see instructions)	138,198,483	0	138,198,483	0	138,198,483	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
7/30/2020 8:13 am

			Title XVIII			Hospital	PPS		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	28,899,375		28,899,375			30.00	
31.00	03100	INTENSIVE CARE UNIT	23,071,783		23,071,783			31.00	
40.00	04000	SUBPROVIDER - IPF	0		0			40.00	
41.00	04100	SUBPROVIDER - IRF	2,719,340		2,719,340			41.00	
42.00	04200	SUBPROVIDER	0		0			42.00	
43.00	04300	NURSERY	13,521,785		13,521,785			43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	21,818,060	21,215,385	43,033,445	0.291332	0.000000	50.00	
51.00	05100	RECOVERY ROOM	1,700,420	1,978,058	3,678,478	0.330845	0.000000	51.00	
53.00	05300	ANESTHESIOLOGY	4,191,237	3,568,154	7,759,391	0.038088	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,565,619	31,179,033	39,744,652	0.169678	0.000000	54.00	
57.00	05700	CT SCAN	10,713,361	27,132,753	37,846,114	0.053223	0.000000	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00	
60.00	06000	LABORATORY	22,181,991	28,527,023	50,709,014	0.116848	0.000000	60.00	
64.00	06400	INTRAVENOUS THERAPY	2,081,540	6,606,138	8,687,678	0.439431	0.000000	64.00	
65.00	06500	RESPIRATORY THERAPY	4,806,427	581,196	5,387,623	0.353839	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	3,412,082	3,647,142	7,059,224	0.403188	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	2,664,406	547,756	3,212,162	0.230110	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	772,817	237,999	1,010,816	0.396724	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	13,402,490	22,427,984	35,830,474	0.157793	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	261,250	739,750	1,001,000	0.250197	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,561,993	6,352,614	14,914,607	0.997965	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	18,703,483	8,833,896	27,537,379	0.461406	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	49,543,059	28,366,474	77,909,533	0.121457	0.000000	73.00	
76.97	07697	CARDIAC REHABILITATION	50,460	690,653	741,113	0.968920	0.000000	76.97	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,425,379	1,425,379	0.683411	0.000000	90.00	
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0.000000	0.000000	90.01	
90.03	09002	PSYCH OUTPATIENT	0	842,600	842,600	0.973005	0.000000	90.03	
90.04	09003	WOUND CARE CLINIC	380,515	5,692,582	6,073,097	0.268401	0.000000	90.04	
91.00	09100	EMERGENCY	9,037,292	30,791,891	39,829,183	0.230599	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,031,350	6,710,099	8,741,449	0.535622	0.000000	92.00	
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0.000000	0.000000	93.00	
	OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0			99.10	
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00	
	SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00	
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00	
111.00	11100	ISLET ACQUISITION	0	0	0			111.00	
113.00	11300	INTEREST EXPENSE						113.00	
116.00	11600	HOSPICE	0	0	0			116.00	
200.00		Subtotal (see instructions)	253,092,135	238,094,559	491,186,694			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	253,092,135	238,094,559	491,186,694			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
7/30/2020 8:13 am

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF				41.00
42.00	04200	SUBPROVIDER				42.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.291332			50.00
51.00	05100	RECOVERY ROOM	0.330845			51.00
53.00	05300	ANESTHESIOLOGY	0.038088			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169678			54.00
57.00	05700	CT SCAN	0.053223			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.116848			60.00
64.00	06400	INTRAVENOUS THERAPY	0.439431			64.00
65.00	06500	RESPIRATORY THERAPY	0.353839			65.00
66.00	06600	PHYSICAL THERAPY	0.403188			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.230110			67.00
68.00	06800	SPEECH PATHOLOGY	0.396724			68.00
69.00	06900	ELECTROCARDIOLOGY	0.157793			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.250197			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.997965			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.461406			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.121457			73.00
76.97	07697	CARDIAC REHABILITATION	0.968920			76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.683411			90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000			90.01
90.03	09002	PSYCH OUTPATIENT	0.973005			90.03
90.04	09003	WOUND CARE CLINIC	0.268401			90.04
91.00	09100	EMERGENCY	0.230599			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.535622			92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000			93.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION				109.00
110.00	11000	INTESTINAL ACQUISITION				110.00
111.00	11100	ISLET ACQUISITION				111.00
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE				116.00
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: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
7/30/2020 8:13 am

			Title XIX		Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
					Total Costs	RCE Disallowance	Total Costs
			1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	19,244,336		19,244,336	0	19,244,336
31.00	03100	INTENSIVE CARE UNIT	17,081,640		17,081,640	0	17,081,640
40.00	04000	SUBPROVIDER - IPF	0		0	0	0
41.00	04100	SUBPROVIDER - IRF	2,704,647		2,704,647	0	2,704,647
42.00	04200	SUBPROVIDER	0		0	0	0
43.00	04300	NURSERY	4,440,899		4,440,899	0	4,440,899
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	12,537,030		12,537,030	0	12,537,030
51.00	05100	RECOVERY ROOM	1,217,006		1,217,006	0	1,217,006
53.00	05300	ANESTHESIOLOGY	295,538		295,538	0	295,538
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,743,798		6,743,798	0	6,743,798
57.00	05700	CT SCAN	2,014,267		2,014,267	0	2,014,267
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0
60.00	06000	LABORATORY	5,925,248		5,925,248	0	5,925,248
64.00	06400	INTRAVENOUS THERAPY	3,817,636		3,817,636	0	3,817,636
65.00	06500	RESPIRATORY THERAPY	1,906,353	0	1,906,353	0	1,906,353
66.00	06600	PHYSICAL THERAPY	2,846,195	0	2,846,195	0	2,846,195
67.00	06700	OCCUPATIONAL THERAPY	739,152	0	739,152	0	739,152
68.00	06800	SPEECH PATHOLOGY	401,015	0	401,015	0	401,015
69.00	06900	ELECTROCARDIOLOGY	5,653,786		5,653,786	0	5,653,786
70.00	07000	ELECTROENCEPHALOGRAPHY	250,447		250,447	0	250,447
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,884,260		14,884,260	0	14,884,260
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	12,705,919		12,705,919	0	12,705,919
73.00	07300	DRUGS CHARGED TO PATIENTS	9,462,653		9,462,653	0	9,462,653
76.97	07697	CARDIAC REHABILITATION	718,079		718,079	0	718,079
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	974,120		974,120	0	974,120
90.01	09001	BASIC DIAGNOSTIC TESTING	0		0	0	0
90.03	09002	PSYCH OUTPATIENT	819,854		819,854	0	819,854
90.04	09003	WOUND CARE CLINIC	1,630,025		1,630,025	0	1,630,025
91.00	09100	EMERGENCY	9,184,580		9,184,580	0	9,184,580
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,682,111		4,682,111	0	4,682,111
93.00	04040	OTHER OUTPATIENT SERVICES	0		0	0	0
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0		0		0
101.00	10100	HOME HEALTH AGENCY	0		0		0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0		0		0
110.00	11000	INTESTINAL ACQUISITION	0		0		0
111.00	11100	ISLET ACQUISITION	0		0		0
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	0		0		0
200.00		Subtotal (see instructions)	142,880,594	0	142,880,594	0	142,880,594
201.00		Less Observation Beds	4,682,111		4,682,111		4,682,111
202.00		Total (see instructions)	138,198,483	0	138,198,483	0	138,198,483

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
7/30/2020 8:13 am

			Title XIX			Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	28,899,375		28,899,375			30.00	
31.00	03100	INTENSIVE CARE UNIT	23,071,783		23,071,783			31.00	
40.00	04000	SUBPROVIDER - IPF	0		0			40.00	
41.00	04100	SUBPROVIDER - IRF	2,719,340		2,719,340			41.00	
42.00	04200	SUBPROVIDER	0		0			42.00	
43.00	04300	NURSERY	13,521,785		13,521,785			43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	21,818,060	21,215,385	43,033,445	0.291332	0.000000	50.00	
51.00	05100	RECOVERY ROOM	1,700,420	1,978,058	3,678,478	0.330845	0.000000	51.00	
53.00	05300	ANESTHESIOLOGY	4,191,237	3,568,154	7,759,391	0.038088	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,565,619	31,179,033	39,744,652	0.169678	0.000000	54.00	
57.00	05700	CT SCAN	10,713,361	27,132,753	37,846,114	0.053223	0.000000	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00	
60.00	06000	LABORATORY	22,181,991	28,527,023	50,709,014	0.116848	0.000000	60.00	
64.00	06400	INTRAVENOUS THERAPY	2,081,540	6,606,138	8,687,678	0.439431	0.000000	64.00	
65.00	06500	RESPIRATORY THERAPY	4,806,427	581,196	5,387,623	0.353839	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	3,412,082	3,647,142	7,059,224	0.403188	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	2,664,406	547,756	3,212,162	0.230110	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	772,817	237,999	1,010,816	0.396724	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	13,402,490	22,427,984	35,830,474	0.157793	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	261,250	739,750	1,001,000	0.250197	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,561,993	6,352,614	14,914,607	0.997965	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	18,703,483	8,833,896	27,537,379	0.461406	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	49,543,059	28,366,474	77,909,533	0.121457	0.000000	73.00	
76.97	07697	CARDIAC REHABILITATION	50,460	690,653	741,113	0.968920	0.000000	76.97	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,425,379	1,425,379	0.683411	0.000000	90.00	
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0.000000	0.000000	90.01	
90.03	09002	PSYCH OUTPATIENT	0	842,600	842,600	0.973005	0.000000	90.03	
90.04	09003	WOUND CARE CLINIC	380,515	5,692,582	6,073,097	0.268401	0.000000	90.04	
91.00	09100	EMERGENCY	9,037,292	30,791,891	39,829,183	0.230599	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,031,350	6,710,099	8,741,449	0.535622	0.000000	92.00	
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0.000000	0.000000	93.00	
	OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0			99.10	
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00	
	SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00	
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00	
111.00	11100	ISLET ACQUISITION	0	0	0			111.00	
113.00	11300	INTEREST EXPENSE						113.00	
116.00	11600	HOSPICE	0	0	0			116.00	
200.00		Subtotal (see instructions)	253,092,135	238,094,559	491,186,694			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	253,092,135	238,094,559	491,186,694			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
7/30/2020 8:13 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF				41.00
42.00	04200	SUBPROVIDER				42.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000			90.01
90.03	09002	PSYCH OUTPATIENT	0.000000			90.03
90.04	09003	WOUND CARE CLINIC	0.000000			90.04
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000			93.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION				109.00
110.00	11000	INTESTINAL ACQUISITION				110.00
111.00	11100	ISLET ACQUISITION				111.00
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE				116.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part I
Date/Time Prepared:
7/30/2020 8:13 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	1,916,141	0	1,916,141	19,326	99.15	30.00
31.00	INTENSIVE CARE UNIT	1,653,855		1,653,855	13,516	122.36	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	280,677	0	280,677	2,569	109.26	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	301,421		301,421	3,803	79.26	43.00
200.00	Total (lines 30 through 199)	4,152,094		4,152,094	39,214		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	5,327	528,172				30.00
31.00	INTENSIVE CARE UNIT	5,221	638,842				31.00
40.00	SUBPROVIDER - IPF	0	0				40.00
41.00	SUBPROVIDER - IRF	1,365	149,140				41.00
42.00	SUBPROVIDER	0	0				42.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	11,913	1,316,154				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part II
Date/Time Prepared:
7/30/2020 8:13 am

			Title XVIII		Hospital	PPS		
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,732,983	43,033,445	0.040271	8,926,197	359,467	50.00
51.00	05100	RECOVERY ROOM	83,616	3,678,478	0.022731	702,990	15,980	51.00
53.00	05300	ANESTHESIOLOGY	57,615	7,759,391	0.007425	1,586,962	11,783	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,703,418	39,744,652	0.042859	3,863,362	165,580	54.00
57.00	05700	CT SCAN	523,639	37,846,114	0.013836	4,976,147	68,850	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	506,263	50,709,014	0.009984	8,890,449	88,762	60.00
64.00	06400	INTRAVENOUS THERAPY	264,069	8,687,678	0.030396	793,175	24,109	64.00
65.00	06500	RESPIRATORY THERAPY	198,965	5,387,623	0.036930	1,966,935	72,639	65.00
66.00	06600	PHYSICAL THERAPY	227,888	7,059,224	0.032282	1,134,302	36,618	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,044	3,212,162	0.001882	686,815	1,293	67.00
68.00	06800	SPEECH PATHOLOGY	3,107	1,010,816	0.003074	208,165	640	68.00
69.00	06900	ELECTROCARDIOLOGY	600,516	35,830,474	0.016760	6,314,802	105,836	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	27,126	1,001,000	0.027099	109,813	2,976	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	86,125	14,914,607	0.005775	3,756,481	21,694	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	98,670	27,537,379	0.003583	8,736,299	31,302	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	322,057	77,909,533	0.004134	18,447,010	76,260	73.00
76.97	07697	CARDIAC REHABILITATION	62,807	741,113	0.084747	24,055	2,039	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	11,347	1,425,379	0.007961	0	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0.000000	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	115,738	842,600	0.137358	0	0	90.03
90.04	09003	WOUND CARE CLINIC	28,343	6,073,097	0.004667	171,435	800	90.04
91.00	09100	EMERGENCY	665,107	39,829,183	0.016699	3,621,104	60,469	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	466,193	8,741,449	0.053331	853,075	45,495	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0.000000	0	0	93.00
200.00		Total (lines 50 through 199)	7,791,636	422,974,411		75,769,573	1,192,592	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0127		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part III Date/Time Prepared: 7/30/2020 8:13 am		
Cost Center Description				Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		PPS	
				1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	282,584	0	0		30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	13,065	0	0		31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0		40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	7,487	0	0		41.00	
42.00	04200	SUBPROVIDER	0	0	0	0	0	0		42.00	
43.00	04300	NURSERY	0	0	0	0	0	0		43.00	
200.00		Total (lines 30 through 199)	0	0	0	303,136	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	282,584	19,326	14.62	5,327		30.00		
31.00	03100	INTENSIVE CARE UNIT	0	13,065	13,516	0.97	5,221		31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0		40.00		
41.00	04100	SUBPROVIDER - IRF	0	7,487	2,569	2.91	1,365		41.00		
42.00	04200	SUBPROVIDER	0	0	0	0.00	0		42.00		
43.00	04300	NURSERY	0	0	3,803	0.00	0		43.00		
200.00		Total (lines 30 through 199)	0	303,136	39,214		11,913		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	77,881								30.00
31.00	03100	INTENSIVE CARE UNIT	5,064								31.00
40.00	04000	SUBPROVIDER - IPF	0								40.00
41.00	04100	SUBPROVIDER - IRF	3,972								41.00
42.00	04200	SUBPROVIDER	0								42.00
43.00	04300	NURSERY	0								43.00
200.00		Total (lines 30 through 199)	86,917								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0127		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 7/30/2020 8:13 am	
			Title XVIII		Hospital		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	15,514	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	21,579	54.00
57.00	05700	CT SCAN	0	0	0	0	6,066	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	6,066	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
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	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	0	0	0	0	15,514	90.04
91.00	09100	EMERGENCY	0	0	0	0	95,418	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	68,752	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
200.00		Total (lines 50 through 199)	0	0	0	0	228,909	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
7/30/2020 8:13 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	15,514	15,514	43,033,445	0.000361	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,678,478	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	7,759,391	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	21,579	21,579	39,744,652	0.000543	54.00
57.00	05700	CT SCAN	0	6,066	6,066	37,846,114	0.000160	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	50,709,014	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	8,687,678	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	5,387,623	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,059,224	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,212,162	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,010,816	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	6,066	6,066	35,830,474	0.000169	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,001,000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	14,914,607	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	27,537,379	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	77,909,533	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	741,113	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	1,425,379	0.000000	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0.000000	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	842,600	0.000000	90.03
90.04	09003	WOUND CARE CLINIC	0	15,514	15,514	6,073,097	0.002555	90.04
91.00	09100	EMERGENCY	0	95,418	95,418	39,829,183	0.002396	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	68,752	68,752	8,741,449	0.007865	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0.000000	93.00
200.00		Total (lines 50 through 199)	0	228,909	228,909	422,974,411		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0127

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

Worksheet D
Part IV
Date/Time Prepared:
7/30/2020 8:13 am

				Title XVIII		Hospital	PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000361	8,926,197	3,222	4,133,353	1,492	50.00
51.00	05100	RECOVERY ROOM	0.000000	702,990	0	353,598	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	1,586,962	0	637,711	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000543	3,863,362	2,098	6,983,478	3,792	54.00
57.00	05700	CT SCAN	0.000160	4,976,147	796	6,029,199	965	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	8,890,449	0	4,674,216	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	793,175	0	1,456,726	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,966,935	0	87,284	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,134,302	0	27,555	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	686,815	0	14,660	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	208,165	0	7,870	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000169	6,314,802	1,067	8,590,515	1,452	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	109,813	0	93,268	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	3,756,481	0	1,847,561	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	8,736,299	0	3,765,169	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	18,447,010	0	4,710,395	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	24,055	0	483,114	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	43,944	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0.000000	0	0	115,952	0	90.03
90.04	09003	WOUND CARE CLINIC	0.002555	171,435	438	2,519,654	6,438	90.04
91.00	09100	EMERGENCY	0.002396	3,621,104	8,676	4,332,986	10,382	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.007865	853,075	6,709	1,940,368	15,261	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000	0	0	0	0	93.00
200.00		Total (lines 50 through 199)		75,769,573	23,006	52,848,576	39,782	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0127		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part V Date/Time Prepared: 7/30/2020 8:13 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		0.291332	4,133,353	0	0	1,204,178	50.00
51.00	05100	RECOVERY ROOM		0.330845	353,598	0	0	116,986	51.00
53.00	05300	ANESTHESIOLOGY		0.038088	637,711	0	0	24,289	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.169678	6,983,478	0	0	1,184,943	54.00
57.00	05700	CT SCAN		0.053223	6,029,199	0	0	320,892	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY		0.116848	4,674,216	0	0	546,173	60.00
64.00	06400	INTRAVENOUS THERAPY		0.439431	1,456,726	0	0	640,131	64.00
65.00	06500	RESPIRATORY THERAPY		0.353839	87,284	0	0	30,884	65.00
66.00	06600	PHYSICAL THERAPY		0.403188	27,555	0	0	11,110	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.230110	14,660	0	0	3,373	67.00
68.00	06800	SPEECH PATHOLOGY		0.396724	7,870	0	0	3,122	68.00
69.00	06900	ELECTROCARDIOLOGY		0.157793	8,590,515	0	0	1,355,523	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.250197	93,268	0	0	23,335	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.997965	1,847,561	0	0	1,843,801	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT		0.461406	3,765,169	0	0	1,737,272	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.121457	4,710,395	0	49,020	572,110	73.00
76.97	07697	CARDIAC REHABILITATION		0.968920	483,114	0	0	468,099	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.683411	43,944	0	0	30,032	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING		0.000000	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT		0.973005	115,952	0	0	112,822	90.03
90.04	09003	WOUND CARE CLINIC		0.268401	2,519,654	0	0	676,278	90.04
91.00	09100	EMERGENCY		0.230599	4,332,986	0	0	999,182	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.535622	1,940,368	0	0	1,039,304	92.00
93.00	04040	OTHER OUTPATIENT SERVICES		0.000000	0	0	0	0	93.00
200.00		Subtotal (see instructions)			52,848,576	0	49,020	12,943,839	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0	0	201.00
202.00		Net Charges (line 200 - line 201)			52,848,576	0	49,020	12,943,839	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0127		Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prepared: 7/30/2020 8:13 am
			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,954		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0		90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0		90.01
90.03	09002	PSYCH OUTPATIENT	0	0		90.03
90.04	09003	WOUND CARE CLINIC	0	0		90.04
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0		93.00
200.00		Subtotal (see instructions)	0	5,954		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	5,954		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0127 Component CCN: 14-T127		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part II Date/Time Prepared: 7/30/2020 8:13 am	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,732,983	43,033,445	0.040271	2,055	83	50.00	
51.00	05100	RECOVERY ROOM	83,616	3,678,478	0.022731	0	0	51.00	
53.00	05300	ANESTHESIOLOGY	57,615	7,759,391	0.007425	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,703,418	39,744,652	0.042859	83,935	3,597	54.00	
57.00	05700	CT SCAN	523,639	37,846,114	0.013836	74,013	1,024	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00	
60.00	06000	LABORATORY	506,263	50,709,014	0.009984	276,396	2,760	60.00	
64.00	06400	INTRAVENOUS THERAPY	264,069	8,687,678	0.030396	23,791	723	64.00	
65.00	06500	RESPIRATORY THERAPY	198,965	5,387,623	0.036930	75,055	2,772	65.00	
66.00	06600	PHYSICAL THERAPY	227,888	7,059,224	0.032282	680,330	21,962	66.00	
67.00	06700	OCCUPATIONAL THERAPY	6,044	3,212,162	0.001882	748,455	1,409	67.00	
68.00	06800	SPEECH PATHOLOGY	3,107	1,010,816	0.003074	185,955	572	68.00	
69.00	06900	ELECTROCARDIOLOGY	600,516	35,830,474	0.016760	17,775	298	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	27,126	1,001,000	0.027099	2,192	59	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	86,125	14,914,607	0.005775	55,033	318	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	98,670	27,537,379	0.003583	359	1	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	322,057	77,909,533	0.004134	865,801	3,579	73.00	
76.97	07697	CARDIAC REHABILITATION	62,807	741,113	0.084747	0	0	76.97	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	11,347	1,425,379	0.007961	0	0	90.00	
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0.000000	0	0	90.01	
90.03	09002	PSYCH OUTPATIENT	115,738	842,600	0.137358	0	0	90.03	
90.04	09003	WOUND CARE CLINIC	28,343	6,073,097	0.004667	26,570	124	90.04	
91.00	09100	EMERGENCY	665,107	39,829,183	0.016699	5,865	98	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	8,741,449	0.000000	0	0	92.00	
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0.000000	0	0	93.00	
200.00		Total (lines 50 through 199)	7,325,443	422,974,411		3,123,580	39,379	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0127 Component CCN: 14-T127		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 7/30/2020 8:13 am	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	15,514	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	21,579	54.00
57.00	05700	CT SCAN		0	0	0	0	6,066	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	6,066	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
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	BASIC DIAGNOSTIC TESTING		0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT		0	0	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC		0	0	0	0	15,514	90.04
91.00	09100	EMERGENCY		0	0	0	0	95,418	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES		0	0	0	0	0	93.00
200.00		Total (lines 50 through 199)		0	0	0	0	160,157	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0127 Component CCN: 14-T127		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 7/30/2020 8:13 am	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0		15,514	15,514	43,033,445	0.000361	50.00
51.00	05100	RECOVERY ROOM	0		0	0	3,678,478	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0		0	0	7,759,391	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		21,579	21,579	39,744,652	0.000543	54.00
57.00	05700	CT SCAN	0		6,066	6,066	37,846,114	0.000160	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0		0	0	50,709,014	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	8,687,678	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0		0	0	5,387,623	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0		0	0	7,059,224	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		0	0	3,212,162	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0		0	0	1,010,816	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0		6,066	6,066	35,830,474	0.000169	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	1,001,000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	14,914,607	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0		0	0	27,537,379	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		0	0	77,909,533	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	741,113	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0		0	0	1,425,379	0.000000	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0		0	0	0	0.000000	90.01
90.03	09002	PSYCH OUTPATIENT	0		0	0	842,600	0.000000	90.03
90.04	09003	WOUND CARE CLINIC	0		15,514	15,514	6,073,097	0.002555	90.04
91.00	09100	EMERGENCY	0		95,418	95,418	39,829,183	0.002396	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0	0	8,741,449	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0		0	0	0	0.000000	93.00
200.00		Total (lines 50 through 199)	0		160,157	160,157	422,974,411		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0127 Component CCN: 14-T127		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 7/30/2020 8:13 am	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000361	2,055	1	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000543	83,935	46	0	0	0	54.00
57.00	05700	CT SCAN	0.000160	74,013	12	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	276,396	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	23,791	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	75,055	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	680,330	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	748,455	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	185,955	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000169	17,775	3	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	2,192	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	55,033	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	359	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	865,801	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0.000000	0	0	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	0.002555	26,570	68	0	0	0	90.04
91.00	09100	EMERGENCY	0.002396	5,865	14	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000	0	0	0	0	0	93.00
200.00		Total (lines 50 through 199)		3,123,580	144	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
7/30/2020 8:13 am

			Title XIX		Hospital		Cost	
	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	0.291332	0	408,244	0	0	50.00
51.00	05100	RECOVERY ROOM	0.330845	0	61,470	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.038088	0	83,600	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169678	0	670,263	0	0	54.00
57.00	05700	CT SCAN	0.053223	0	710,975	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.116848	0	807,438	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.439431	0	185,745	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.353839	0	22,354	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.403188	0	61,628	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.230110	0	7,470	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.396724	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.157793	0	194,816	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.250197	0	5,740	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.997965	0	55,408	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.461406	0	19,243	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.121457	0	528,267	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.968920	0	9,540	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.683411	0	13,306	0	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0.973005	0	4,540	0	0	90.03
90.04	09003	WOUND CARE CLINIC	0.268401	0	12,450	0	0	90.04
91.00	09100	EMERGENCY	0.230599	0	1,763,437	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.535622	0	143,271	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000	0	0	0	0	93.00
200.00		Subtotal (see instructions)		0	5,769,205	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	5,769,205	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
7/30/2020 8:13 am

			Title XIX		Hospital	Cost
	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	118,935	0		50.00
51.00	05100	RECOVERY ROOM	20,337	0		51.00
53.00	05300	ANESTHESIOLOGY	3,184	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	113,729	0		54.00
57.00	05700	CT SCAN	37,840	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	94,348	0		60.00
64.00	06400	INTRAVENOUS THERAPY	81,622	0		64.00
65.00	06500	RESPIRATORY THERAPY	7,910	0		65.00
66.00	06600	PHYSICAL THERAPY	24,848	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,719	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	30,741	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,436	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	55,295	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,879	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	64,162	0		73.00
76.97	07697	CARDIAC REHABILITATION	9,243	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	9,093	0		90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0		90.01
90.03	09002	PSYCH OUTPATIENT	4,417	0		90.03
90.04	09003	WOUND CARE CLINIC	3,342	0		90.04
91.00	09100	EMERGENCY	406,647	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	76,739	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0		93.00
200.00		Subtotal (see instructions)	1,174,466	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	1,174,466	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0127	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 7/30/2020 8:13 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)		19,326	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		19,326	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)		14,624	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)		5,327	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)		19,244,336	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)		19,244,336	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)		19,244,336	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)		995.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,304,467	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)		5,304,467	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0127

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

Worksheet D-1

Date/Time Prepared:
7/30/2020 8:13 am

		Title XVIII		Hospital		PPS		
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00	
	Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	17,081,640	13,516	1,263.81	5,221	6,598,352	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)						19,000,716	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						30,903,535	49.00
	PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						1,249,959	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						1,215,598	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						2,465,557	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						28,437,978	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)						4,702	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						995.77	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						4,682,111	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0127

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

Worksheet D-1

Date/Time Prepared:
7/30/2020 8:13 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	1,916,141	19,244,336	0.099569	4,682,111	466,193	90.00
91.00 Nursing School cost	0	19,244,336	0.000000	4,682,111	0	91.00
92.00 Allied health cost	282,584	19,244,336	0.014684	4,682,111	68,752	92.00
93.00 All other Medical Education	0	19,244,336	0.000000	4,682,111	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0127 Component CCN: 14-T127	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 7/30/2020 8:13 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,569	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,569	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,569	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)		1,365	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,704,647	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,704,647	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,704,647	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)		1,052.80	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,437,072	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)		1,437,072	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0127 Component CCN: 14-T127	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 7/30/2020 8:13 am
			Title XVIII	Subprovider - IRF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0
44.00 CORONARY CARE UNIT					
45.00 BURN INTENSIVE CARE UNIT					
46.00 SURGICAL INTENSIVE CARE UNIT					
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)					780,470
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,217,542
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					153,112
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					39,523
52.00 Total Program excludable cost (sum of lines 50 and 51)					192,635
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,024,907
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: 14-0127 Component CCN: 14-T127		Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 7/30/2020 8:13 am	
			Title XVIII		Subprovider - IRF	PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	280,677	2,704,647	0.103776	0	0	90.00
91.00	Nursing School cost	0	2,704,647	0.000000	0	0	91.00
92.00	Allied health cost	7,487	2,704,647	0.002768	0	0	92.00
93.00	All other Medical Education	0	2,704,647	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0127	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 7/30/2020 8:13 am	
			Title XVIII	Hospital	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		7,419,934		30.00
31.00	03100	INTENSIVE CARE UNIT		10,767,831		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.291332	8,926,197	2,600,487	50.00
51.00	05100	RECOVERY ROOM	0.330845	702,990	232,581	51.00
53.00	05300	ANESTHESIOLOGY	0.038088	1,586,962	60,444	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169678	3,863,362	655,528	54.00
57.00	05700	CT SCAN	0.053223	4,976,147	264,845	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.116848	8,890,449	1,038,831	60.00
64.00	06400	INTRAVENOUS THERAPY	0.439431	793,175	348,546	64.00
65.00	06500	RESPIRATORY THERAPY	0.353839	1,966,935	695,978	65.00
66.00	06600	PHYSICAL THERAPY	0.403188	1,134,302	457,337	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.230110	686,815	158,043	67.00
68.00	06800	SPEECH PATHOLOGY	0.396724	208,165	82,584	68.00
69.00	06900	ELECTROCARDIOLOGY	0.157793	6,314,802	996,432	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.250197	109,813	27,475	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.997965	3,756,481	3,748,837	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.461406	8,736,299	4,030,981	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.121457	18,447,010	2,240,518	73.00
76.97	07697	CARDIAC REHABILITATION	0.968920	24,055	23,307	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.683411	0	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0.973005	0	0	90.03
90.04	09003	WOUND CARE CLINIC	0.268401	171,435	46,013	90.04
91.00	09100	EMERGENCY	0.230599	3,621,104	835,023	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.535622	853,075	456,926	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		75,769,573	19,000,716	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)		75,769,573		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0127 Component CCN: 14-T127	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 7/30/2020 8:13 am	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		1,428,850		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.291332	2,055	599	50.00
51.00	05100 RECOVERY ROOM	0.330845	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.038088	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.169678	83,935	14,242	54.00
57.00	05700 CT SCAN	0.053223	74,013	3,939	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.116848	276,396	32,296	60.00
64.00	06400 INTRAVENOUS THERAPY	0.439431	23,791	10,455	64.00
65.00	06500 RESPIRATORY THERAPY	0.353839	75,055	26,557	65.00
66.00	06600 PHYSICAL THERAPY	0.403188	680,330	274,301	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.230110	748,455	172,227	67.00
68.00	06800 SPEECH PATHOLOGY	0.396724	185,955	73,773	68.00
69.00	06900 ELECTROCARDIOLOGY	0.157793	17,775	2,805	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.250197	2,192	548	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.997965	55,033	54,921	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.461406	359	166	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.121457	865,801	105,158	73.00
76.97	07697 CARDIAC REHABILITATION	0.968920	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.683411	0	0	90.00
90.01	09001 BASIC DIAGNOSTIC TESTING	0.000000	0	0	90.01
90.03	09002 PSYCH OUTPATIENT	0.973005	0	0	90.03
90.04	09003 WOUND CARE CLINIC	0.268401	26,570	7,131	90.04
91.00	09100 EMERGENCY	0.230599	5,865	1,352	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.535622	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICES	0.000000	0	0	93.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		3,123,580	780,470	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)		3,123,580		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0127	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 7/30/2020 8:13 am
			Title XIX	Hospital	Cost
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,143,660	30.00
31.00	03100	INTENSIVE CARE UNIT		505,755	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		1,712,540	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.291332	159,337	50.00
51.00	05100	RECOVERY ROOM	0.330845	13,175	51.00
53.00	05300	ANESTHESIOLOGY	0.038088	36,497	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169678	216,571	54.00
57.00	05700	CT SCAN	0.053223	262,150	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.116848	677,210	60.00
64.00	06400	INTRAVENOUS THERAPY	0.439431	37,963	64.00
65.00	06500	RESPIRATORY THERAPY	0.353839	113,737	65.00
66.00	06600	PHYSICAL THERAPY	0.403188	14,275	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.230110	12,797	67.00
68.00	06800	SPEECH PATHOLOGY	0.396724	9,580	68.00
69.00	06900	ELECTROCARDIOLOGY	0.157793	307,142	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.250197	8,157	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.997965	77,102	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.461406	76,696	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.121457	1,102,250	73.00
76.97	07697	CARDIAC REHABILITATION	0.968920	965	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.683411	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000	0	90.01
90.03	09002	PSYCH OUTPATIENT	0.973005	0	90.03
90.04	09003	WOUND CARE CLINIC	0.268401	4,640	90.04
91.00	09100	EMERGENCY	0.230599	291,956	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.535622	21,022	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,443,222	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)		3,443,222	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0127 Component CCN: 14-T127	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 7/30/2020 8:13 am	
		Title XIX	Subprovider - IRF	Cost	
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
41.00	04100 SUBPROVIDER - IRF		75,920		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.291332	0	0	50.00
51.00	05100 RECOVERY ROOM	0.330845	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.038088	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.169678	4,570	775	54.00
57.00	05700 CT SCAN	0.053223	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.116848	7,720	902	60.00
64.00	06400 INTRAVENOUS THERAPY	0.439431	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.353839	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.403188	34,570	13,938	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.230110	37,130	8,544	67.00
68.00	06800 SPEECH PATHOLOGY	0.396724	15,200	6,030	68.00
69.00	06900 ELECTROCARDIOLOGY	0.157793	585	92	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.250197	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.997965	1,240	1,237	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.461406	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.121457	77,063	9,360	73.00
76.97	07697 CARDIAC REHABILITATION	0.968920	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.683411	0	0	90.00
90.01	09001 BASIC DIAGNOSTIC TESTING	0.000000	0	0	90.01
90.03	09002 PSYCH OUTPATIENT	0.973005	0	0	90.03
90.04	09003 WOUND CARE CLINIC	0.268401	940	252	90.04
91.00	09100 EMERGENCY	0.230599	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.535622	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICES	0.000000	0	0	93.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		179,018	41,130	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)		179,018		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0127	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 7/30/2020 8:13 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)		17,797,604	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		6,310,054	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)		407,611	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		0	2.04
3.00	Managed Care Simulated Payments		10,024,127	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		191.71	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		13.60	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.		1.03	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)		12.57	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		13.76	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)		12.57	12.00
13.00	Total allowable FTE count for the prior year.		12.57	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.		12.57	14.00
15.00	Sum of lines 12 through 14 divided by 3.		12.57	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		12.57	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.065568	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.064133	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.064133	21.00
22.00	IME payment adjustment (see instructions)		829,737	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		345,010	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		1.19	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)		829,737	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		345,010	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.54	30.00
31.00	Percentage of Medicaid patient days (see instructions)		20.16	31.00
32.00	Sum of lines 30 and 31		24.70	32.00
33.00	Allowable disproportionate share percentage (see instructions)		9.59	33.00
34.00	Disproportionate share adjustment (see instructions)		577,982	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0127	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 7/30/2020 8:13 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)		0.000301311	0.000146526
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		2,492,708	1,223,578
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		1,864,408	307,566
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		2,171,974	
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)		28,094,962	
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)		28,439,972	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,171,622	
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		490,334	
53.00	Nursing and Allied Health Managed Care payment		121,300	
54.00	Special add-on payments for new technologies		0	
54.01	Islet isolation add-on payment		0	
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		82,945	
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		23,006	
59.00	Total (sum of amounts on lines 49 through 58)		31,329,179	
60.00	Primary payer payments		43,070	
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		31,286,109	
62.00	Deductibles billed to program beneficiaries		2,592,388	
63.00	Coinurance billed to program beneficiaries		21,142	
64.00	Allowable bad debts (see instructions)		531,466	
65.00	Adjusted reimbursable bad debts (see instructions)		345,453	
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		341,581	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		29,018,032	
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	
70.00	OTHER ADJUSTMENTS PER PS&R		-4,333	
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	
70.87	Demonstration payment adjustment amount before sequestration		0	
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	
70.92	Bundled Model 1 discount amount (see instructions)		0	
70.93	HVBP payment adjustment amount (see instructions)		152,135	
70.94	HRR adjustment amount (see instructions)		-8,203	
70.95	Recovery of accelerated depreciation		0	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0127	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 7/30/2020 8:13 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		29,157,631	71.00
71.01	Sequestration adjustment (see instructions)		583,153	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		28,605,633	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-31,155	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		455,231	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

Health Financial Systems		ADVOCATE BROMENN MEDICAL CENTER		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0127	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 7/30/2020 8:13 am	
		Title XVIII	Hospital	PPS	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)			5,954	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			12,904,057	2.00
3.00	OPPS payments			10,622,958	3.00
4.00	Outlier payment (see instructions)			45,117	4.00
4.01	Outlier reconciliation amount (see instructions)			0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.757	5.00
6.00	Line 2 times line 5			9,768,371	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			39,782	9.00
10.00	Organ acquisitions			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			5,954	11.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges			49,020	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)			49,020	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)			49,020	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			43,066	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)			5,954	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)			10,707,857	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			1,866,133	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			8,847,678	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			191,962	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)			9,039,640	30.00
31.00	Primary payer payments			0	31.00
32.00	Subtotal (line 30 minus line 31)			9,039,640	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)			321,193	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			208,775	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			213,137	36.00
37.00	Subtotal (see instructions)			9,248,415	37.00
38.00	MSP-LCC reconciliation amount from PS&R			0	38.00
39.00	OTHER ADJUSTMENTS PER PS&R			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)			9,248,415	40.00
40.01	Sequestration adjustment (see instructions)			184,968	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			9,016,930	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)			46,517	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: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part I
Date/Time Prepared:
7/30/2020 8:13 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		28,655,213		9,043,764	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	08/07/2019	49,580	08/07/2019	26,834	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)		-49,580		-26,834	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)		28,605,633		9,016,930	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		46,517	6.01	
6.02	SETTLEMENT TO PROGRAM		31,155		0	6.02	
7.00	Total Medicare program liability (see instructions)		28,574,478		9,063,447	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: 14-0127
 Component CCN: 14-T127

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

 Worksheet E-1
 Part I
 Date/Time Prepared:
 7/30/2020 8:13 am

		Title XVIII		Subprovider - IRF		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,142,843		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,142,843		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		22,873		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,165,716		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part II
Date/Time Prepared:
7/30/2020 8:13 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: 14-0127 Component CCN: 14-T127	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part III Date/Time Prepared: 7/30/2020 8:13 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)		2,125,549	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0.0221	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		63,554	3.00
4.00	Outlier Payments		37,747	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)		0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	5.01
6.00	New Teaching program adjustment. (see instructions)		0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)		0.00	9.00
10.00	Average Daily Census (see instructions)		7.038356	10.00
11.00	Teaching Adjustment Factor (see instructions)		0.000000	11.00
12.00	Teaching Adjustment (see instructions)		0	12.00
13.00	Total PPS Payment (see instructions)		2,226,850	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)		0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)		0	16.00
17.00	Subtotal (see instructions)		2,226,850	17.00
18.00	Primary payer payments		0	18.00
19.00	Subtotal (line 17 less line 18).		2,226,850	19.00
20.00	Deductibles		17,708	20.00
21.00	Subtotal (line 19 minus line 20)		2,209,142	21.00
22.00	Coinsurance		4,433	22.00
23.00	Subtotal (line 21 minus line 22)		2,204,709	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		1,675	24.00
25.00	Adjusted reimbursable bad debts (see instructions)		1,089	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	26.00
27.00	Subtotal (sum of lines 23 and 25)		2,205,798	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	28.00
29.00	Other pass through costs (see instructions)		4,116	29.00
30.00	Outlier payments reconciliation		0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	31.50
31.99	Demonstration payment adjustment amount before sequestration		0	31.99
32.00	Total amount payable to the provider (see instructions)		2,209,914	32.00
32.01	Sequestration adjustment (see instructions)		44,198	32.01
32.02	Demonstration payment adjustment amount after sequestration		0	32.02
33.00	Interim payments		2,142,843	33.00
34.00	Tentative settlement (for contractor use only)		0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)		22,873	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		8,647	36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4		37,747	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0127	Period: From 01/01/2019 To 12/31/2019	Worksheet E-4 Date/Time Prepared: 7/30/2020 8:13 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.			13.60	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)			1.03	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)			12.57	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			13.76	6.00
7.00	Enter the lesser of line 5 or line 6			12.57	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.	6.02	7.74	13.76	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.	5.50	7.07	12.57	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	5.50	7.07		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	5.34	7.23		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	5.19	6.64		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	5.34	6.98		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	5.34	6.98		17.00
18.00	Per resident amount	104,851.87	104,851.87		18.00
19.00	Approved amount for resident costs	559,909	731,866	1,291,775	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)			1.19	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)			1,291,775	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)	11,913	4,855		26.00
27.00	Total Inpatient Days (see instructions)	31,103	31,103		27.00
28.00	Ratio of inpatient days to total inpatient days	0.383018	0.156094		28.00
29.00	Program direct GME amount	494,773	201,638	696,411	29.00
29.01	Percent reduction for MA DGME		7.00		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		14,115	14,115	30.00
31.00	Net Program direct GME amount			682,296	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0127	Period: From 01/01/2019 To 12/31/2019	Worksheet E-4 Date/Time Prepared: 7/30/2020 8:13 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)			0	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)			33,121,077	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)			43,070	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			33,078,007	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			12,949,793	42.00
43.00	Primary payer payments (see instructions)			0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			12,949,793	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			46,027,800	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.718653	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.281347	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			682,296	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			490,334	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			191,962	50.00

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

Provider CCN: 14-0127

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

Worksheet G

Date/Time Prepared:
7/30/2020 8:13 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	449,712,000	0	0	0	1.00
2.00	Temporary investments	106,529,000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	1,620,938,000	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	637,826,000	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)	2,815,005,000	0	0	0	11.00
FIXED ASSETS						
12.00	Land	497,363,000	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	7,875,340,000	0	0	0	15.00
16.00	Accumulated depreciation	0	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	2,496,988,000	0	0	0	23.00
24.00	Accumulated depreciation	-4,967,768,000	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)	5,901,923,000	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	9,140,565,000	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	1,075,876,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	10,216,441,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	18,933,369,000	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,863,035,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	77,957,000	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	767,958,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,708,950,000	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	2,729,366,000	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,796,389,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	4,525,755,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	7,234,705,000	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	11,698,664,000	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	11,698,664,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	18,933,369,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0127

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

Worksheet G-1

Date/Time Prepared:
7/30/2020 8:13 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		10,242,997,000		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,462,569				2.00
3.00	Total (sum of line 1 and line 2)		10,245,459,569		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	ADJ TO AHC FUND BALANCE	1,453,204,431		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		1,453,204,431		0		10.00
11.00	Subtotal (line 3 plus line 10)		11,698,664,000		0		11.00
12.00	RECONCILING ITEM	0		0		0	12.00
13.00		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)		11,698,664,000		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00	ADJ TO AHC FUND BALANCE		0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	RECONCILING ITEM		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0127

Period:
From 01/01/2019
To 12/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
7/30/2020 8:13 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	42,295,032		42,295,032	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	2,719,340		2,719,340	3.00
4.00	SUBPROVIDER	0		0	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)	45,014,372		45,014,372	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	23,068,351		23,068,351	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)	23,068,351		23,068,351	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	68,082,723		68,082,723	17.00
18.00	Ancillary services	177,469,011	199,955,074	377,424,085	18.00
19.00	Outpatient services	11,449,157	44,619,951	56,069,108	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		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	257,000,891	244,575,025	501,575,916	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		177,085,382		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	IMMATERIAL VARIANCE	73			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		73		36.00
37.00	RECONCILING AMOUNT	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)		177,085,455		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0127

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

Worksheet G-3

Date/Time Prepared:
7/30/2020 8:13 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	501,575,916	1.00
2.00	Less contractual allowances and discounts on patients' accounts	327,030,103	2.00
3.00	Net patient revenues (line 1 minus line 2)	174,545,813	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	177,085,455	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,539,642	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	1,199,640	6.00
7.00	Income from investments	5,993	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	230,259	13.00
14.00	Revenue from meals sold to employees and guests	240,394	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	1,329,514	17.00
18.00	Revenue from sale of medical records and abstracts	682	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	81,757	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	990,809	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	12,000	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER	911,163	24.00
25.00	Total other income (sum of lines 6-24)	5,002,211	25.00
26.00	Total (line 5 plus line 25)	2,462,569	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,462,569	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0127	Period: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III Date/Time Prepared: 7/30/2020 8:13 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,940,409	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		42,993	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)		79.31	3.00
4.00	Number of interns & residents (see instructions)		12.57	4.00
5.00	Indirect medical education percentage (see instructions)		4.57	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)		88,677	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		4.54	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		20.16	8.00
9.00	Sum of lines 7 and 8		24.70	9.00
10.00	Allowable disproportionate share percentage (see instructions)		5.13	10.00
11.00	Disproportionate share adjustment (see instructions)		99,543	11.00
12.00	Total prospective capital payments (see instructions)		2,171,622	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