

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: 14-0130	Period: From 09/01/2018 To 08/31/2019	Worksheet S Parts I-III Date/Time Prepared: 1/29/2020 12:25 pm
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically filed cost report 2. ☐ Manually submitted cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report 4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		Date: 1/29/2020 Time: 12:25 pm
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 NORTHWESTERN LAKE FOREST HOSPITAL (14-0130) for the cost reporting period beginning 09/01/2018 and ending 08/31/2019 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) _____
 Officer or Administrator of Provider(s)

 Title

 Date

Cost Center Description		Title XVIII		HIT	Title XIX	
		Title V	Part A	Part B		
		1.00	2.00	3.00	4.00	5.00
PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	2,004,634	15,873	0	1.00
2.00	Subprovider - IPF	0	0	0	0	2.00
3.00	Subprovider - IRF	0	0	0	0	3.00
5.00	Swing bed - SNF	0	0	0	0	5.00
6.00	Swing bed - NF	0	0	0	0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0	0	7.00
8.00	NURSING FACILITY	0	0	0	0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0	0	9.00
200.00	Total	0	2,004,634	15,873	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: 14-0130		Period: From 09/01/2018 To 08/31/2019		Worksheet S-2 Part I Date/Time Prepared: 1/29/2020 12:25 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 1000 WESTMORELAND ROAD			PO Box:				1.00	
2.00	City: LAKE FOREST			State: IL		Zip Code: 60045		County: LAKE	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			NORTHWESTERN LAKE FOREST HOSPITAL	140130	29404	1	07/01/1966	N P O
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA			NORTHWESTERN LAKE FOREST HOME HEALTH	147045	29404		07/01/1966	N P N
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						09/01/2018	08/31/2019	20.00
21.00	Type of Control (see instructions)						2		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N		23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			1,249	705	39	0	3,349	115

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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

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

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			1.00	
Long Term Care Hospital PPS				
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00
TEFRA Providers				
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00
		V	XIX	
		1.00	2.00	
Title V and XIX Services				
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
Rural Providers				
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00
		Physical	Occupational	Speech
		1.00	2.00	3.00
				Respiratory
				4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			109.00
			1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N		110.00

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			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
			1.00	2.00	3.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	614,876	6,994,824	-2,959,723	118.01
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		HB0640	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0130		Period: From 09/01/2018 To 08/31/2019		Worksheet S-2 Part I Date/Time Prepared: 1/29/2020 12:25 pm		
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: NORTHWESTERN MEMORIAL HEALTHCARE AND		Contractor's Name: NGS		Contractor's Number: 06101				141.00	
142.00	Street: 251 E HURON ST		PO Box:						142.00	
143.00	City: CHICAGO		State: IL		Zip Code: 60611				143.00	
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?								N	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	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital			N	N	N	N			155.00
156.00	Subprovider - IPF			N	N	N	N			156.00
157.00	Subprovider - IRF			N	N	N	N			157.00
158.00	SUBPROVIDER									158.00
159.00	SNF			N	N	N	N			159.00
160.00	HOME HEALTH AGENCY			N	N	N	N			160.00
161.00	CMHC				N	N	N			161.00
								1.00		
Multicampus										
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00
				Name	County	State	Zip Code	CBSA	FTE/Campus	
				0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00	166.00
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								0.01	169.00
						Beginning	Ending			
						1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					09/01/2018	08/31/2019		170.00	
						1.00	2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N		0	171.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0130	Period: From 09/01/2018 To 08/31/2019	Worksheet S-2 Part II Date/Time Prepared: 1/29/2020 12:25 pm
			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	11/30/2019
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	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		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	12/03/2019	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		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		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0130	Period: From 09/01/2018 To 08/31/2019	Worksheet S-2 Part II Date/Time Prepared: 1/29/2020 12:25 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JOHN	VANDER LAAN		41.00
42.00	Enter the employer/company name of the cost report preparer.	NORTHWESTERN MEMORIAL HEALTHCARE			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(312) 926-6618	JVANDERL@NMH.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019Worksheet S-2
Part II
Date/Time Prepared:
1/29/2020 12:25 pm

		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.	MANAGER	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: 14-0130

Period:
From 09/01/2018
To 08/31/2019Worksheet S-3
Part I
Date/Time Prepared:
1/29/2020 12:25 pm

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	102	37,230	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)		102	37,230	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,380	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		114	41,610	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00 NURSING FACILITY	45.00	0	0		0	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						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		114			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		8	2,920			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: 14-0130

Period:
From 09/01/2018
To 08/31/2019Worksheet S-3
Part I
Date/Time Prepared:
1/29/2020 12:25 pm

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)	10,796	696	25,494			1.00
2.00	HMO and other (see instructions)	2,043	3,161				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	10,796	696	25,494			7.00
8.00	INTENSIVE CARE UNIT	2,070	143	3,622			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		379	4,497			13.00
14.00	Total (see instructions)	12,866	1,218	33,613	24.40	1,292.89	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY		0	0	0.00	0.00	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	10,068	0.00	26.35	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			103			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				24.40	1,319.24	27.00
28.00	Observation Bed Days		0	5,458			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	64	1,884			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			151			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: 14-0130

Period:
From 09/01/2018
To 08/31/2019Worksheet S-3
Part I
Date/Time Prepared:
1/29/2020 12:25 pm

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	3,430	348	9,589	1.00
2.00 HMO and other (see instructions)			510	1,054		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	3,430	348	9,589	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY	0.00					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						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019Worksheet S-3
Part II
Date/Time Prepared:
1/29/2020 12:25 pm

		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	104,251,960	-2,100	104,249,860	2,804,828.00	37.17	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	1,509,547	0	1,509,547	50,758.00	29.74	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		2,786,458	0	2,786,458	77,749.00	35.84	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		1,387,185	0	1,387,185	12,186.00	113.83	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		28,494,705	0	28,494,705	696,039.00	40.94	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		24,384,421	0	24,384,421			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		711,215	0	711,215			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		313,174	0	313,174			25.00
25.50	Home office wage-related (core)		6,532,927	0	6,532,927			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	142,987	0	142,987	4,380.00	32.65	26.00
27.00	Administrative & General	5.00	15,089,335	-1,615,242	13,474,093	233,354.00	57.74	27.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019Worksheet S-3
Part II
Date/Time Prepared:
1/29/2020 12:25 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	3,616,148	0	3,616,148	134,671.00	26.85	30.00
31.00	Laundry & Linen Service	8.00	167,204	0	167,204	10,295.00	16.24	31.00
32.00	Housekeeping	9.00	2,214,944	0	2,214,944	126,974.00	17.44	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	118,438	0	118,438	3,853.00	30.74	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	1,321	0	1,321	49.00	26.96	37.00
38.00	Nursing Administration	13.00	5,924,212	11,051	5,935,263	127,211.00	46.66	38.00
39.00	Central Services and Supply	14.00	1,155,515	0	1,155,515	50,328.00	22.96	39.00
40.00	Pharmacy	15.00	2,974,994	0	2,974,994	63,861.00	46.59	40.00
41.00	Medical Records & Medical Records Library	16.00	581,779	0	581,779	19,921.00	29.20	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019Worksheet S-3
Part III
Date/Time Prepared:
1/29/2020 12:25 pm

	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)	102,742,413	-2,100	102,740,313	2,754,070.00	37.30	1.00
2.00	Excluded area salaries (see instructions)	2,786,458	0	2,786,458	77,749.00	35.84	2.00
3.00	Subtotal salaries (line 1 minus line 2)	99,955,955	-2,100	99,953,855	2,676,321.00	37.35	3.00
4.00	Subtotal other wages & related costs (see inst.)	29,881,890	0	29,881,890	708,225.00	42.19	4.00
5.00	Subtotal wage-related costs (see inst.)	30,917,348	0	30,917,348	0.00	30.93	5.00
6.00	Total (sum of lines 3 thru 5)	160,755,193	-2,100	160,753,093	3,384,546.00	47.50	6.00
7.00	Total overhead cost (see instructions)	31,986,877	-1,604,191	30,382,686	774,897.00	39.21	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019Worksheet S-3
Part IV
Date/Time Prepared:
1/29/2020 12:25 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	6,128,535	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	7,117,711	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	2,596,449	9.00
10.00	Dental, Hearing and Vision Plan	352,915	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	81,435	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)	761,456	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	0	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	6,128,535	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	54,383	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	81,387	22.00
23.00	Tuition Reimbursement	323,828	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	23,626,634	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COST	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019Worksheet S-3
Part V
Date/Time Prepared:
1/29/2020 12:25 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	23,626,634	1.00
2.00	Hospital	0	23,626,634	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF	0	0	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			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

Health Financial Systems		NORTHWESTERN LAKE FOREST HOSPITAL			In Lieu of Form CMS-2552-10		
HOME HEALTH AGENCY STATISTICAL DATA				Provider CCN: 14-0130 Component CCN: 14-7045		Period: From 09/01/2018 To 08/31/2019	
				Home Health Agency I		Worksheet S-4 Date/Time Prepared: 1/29/2020 12:25 pm	
						PPS	
				1.00			
0.00 County				LAKE		0.00	
				Title V 1.00	Title XVIII 2.00	Title XIX 3.00	Other 4.00
				Total 5.00			
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	0.00	0.00	0.00	0.00	2.00
		Enter the number of hours in your normal work week		Number of Employees (Full Time Equivalent)			
				Staff	Contract	Total	
				0	1.00	2.00	3.00
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		6.18	0.00	6.18	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			13.28	0.00	13.28	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			4.65	0.00	4.65	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			1.38	0.00	1.38	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.45	0.00	0.45	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.17	0.00	1.17	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	16974					20.00
20.01		29404					20.01
		Full Episodes					
		Without Outliers 1.00	With Outliers 2.00	LUPA Episodes 3.00	PEP Only Episodes 4.00	Total (cols. 1-4) 5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	4,047	1,056	173	201	5,477	21.00
22.00	Skilled Nursing Visit Charges	0	0	0	0	0	22.00
23.00	Physical Therapy Visits	2,390	542	43	96	3,071	23.00
24.00	Physical Therapy Visit Charges	0	0	0	0	0	24.00
25.00	Occupational Therapy Visits	642	217	6	18	883	25.00
26.00	Occupational Therapy Visit Charges	0	0	0	0	0	26.00
27.00	Speech Pathology Visits	1	0	0	0	1	27.00
28.00	Speech Pathology Visit Charges	0	0	0	0	0	28.00
29.00	Medical Social Service Visits	111	101	0	9	221	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	232	166	0	17	415	31.00
32.00	Home Health Aide Visit Charges	0	0	0	0	0	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	7,423	2,082	222	341	10,068	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	0	0	0	0	0	35.00
36.00	Total Number of Episodes (standard/non outlier)	0		0	0	0	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	0	38.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019

Worksheet S-5

Date/Time Prepared:
1/29/2020 12:25 pm

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

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019

Worksheet S-5

Date/Time Prepared:
1/29/2020 12:25 pm

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

Health Financial Systems		NORTHWESTERN LAKE FOREST HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0130	Period: From 09/01/2018 To 08/31/2019	Worksheet S-10 Date/Time Prepared: 1/29/2020 12:25 pm	
				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)			0.200157	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			20,745,187	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			613,000	5.00
6.00	Medicaid charges			210,040,779	6.00
7.00	Medicaid cost (line 1 times line 6)			42,041,132	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)			20,682,945	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)			20,682,945	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)	48,908,556	343,402	49,251,958	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	9,789,390	343,402	10,132,792	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)	9,789,390	343,402	10,132,792	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)			22,716,280	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			450,131	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			692,509	27.01
28.00	Non-Medicare bad debt expense (see instructions)			22,023,771	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			4,650,590	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			14,783,382	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			35,466,327	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019

Worksheet A

Date/Time Prepared:
1/29/2020 12:25 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	21,667,221	21,667,221	-1,081,361	20,585,860	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	13,982,752	13,982,752	0	13,982,752	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	142,987	1,034,236	114,425	1,291,648	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,089,335	117,621,244	-2,663,631	130,046,948	5.00
7.00	00700	OPERATION OF PLANT	3,616,148	13,114,960	1,092,816	17,823,924	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	167,204	867,504	0	1,034,708	8.00
9.00	00900	HOUSEKEEPING	2,214,944	2,028,109	4,243,053	4,243,053	9.00
10.00	01000	DIETARY	118,438	5,373,902	5,492,340	3,070,676	10.00
11.00	01100	CAFETERIA	0	772,289	2,421,664	3,193,953	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	1,321	21,268	22,589	22,589	12.00
13.00	01300	NURSING ADMINISTRATION	5,924,212	1,904,900	7,829,112	7,900,843	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,155,515	2,640,568	3,796,083	3,796,083	14.00
15.00	01500	PHARMACY	2,974,994	44,640,005	47,614,999	5,759,840	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	581,779	342,720	924,499	924,499	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,509,547	313,174	1,822,721	1,822,721	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	58,116	457,061	515,177	515,177	22.00
22.01	02201	EMS PARAMEDICAL PROGRAM	0	0	0	0	22.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	15,620,182	5,604,387	21,224,569	54,159	30.00
31.00	03100	INTENSIVE CARE UNIT	2,987,527	1,567,267	4,554,794	-3,280	31.00
43.00	04300	NURSERY	1,093,852	752,678	1,846,530	393,347	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,995,433	23,782,516	34,777,949	-12,608,790	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,773,219	1,207,607	3,980,826	-31,107	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,405,627	4,180,207	11,585,834	716,368	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,832,614	784,834	2,617,448	0	55.00
57.00	05700	CT SCAN	846,437	469,391	1,315,828	320,561	57.00
58.00	05800	MRI	2,117,457	980,952	3,098,409	425,590	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,538,683	4,160,697	5,699,380	-2,815,451	59.00
60.00	06000	LABORATORY	3,943,674	7,268,799	11,212,473	-73	60.00
65.00	06500	RESPIRATORY THERAPY	1,378,281	504,588	1,882,869	129,344	65.00
66.00	06600	PHYSICAL THERAPY	1,886,687	493,140	2,379,827	101,026	66.00
68.00	06800	SPEECH PATHOLOGY	925,978	473,222	1,399,200	-65,023	68.00
69.00	06900	ELECTROCARDIOLOGY	886,357	237,668	1,124,025	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	319,697	117,088	436,785	148,523	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,082,313	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,596,789	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	41,886,557	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	644,546	203,125	847,671	6,051	76.97
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OP PEDS ONC CLINIC	1,603,632	802,234	2,405,866	-5,518	90.01
90.02	09002	WOUND CLINIC	618,090	999,166	1,617,256	-3,080	90.02
91.00	09100	EMERGENCY	6,207,315	2,860,001	9,067,316	-7,012	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	2,285,674	697,569	2,983,243	-3	92.01
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	2,297,575	695,036	2,992,611	-112	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	103,763,077	285,624,085	389,387,162	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	111,347	23,287	134,634	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	377,536	4,032,245	4,409,781	0	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	0	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	104,251,960	289,679,617	393,931,577	0	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019

Worksheet A

Date/Time Prepared:
1/29/2020 12:25 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	5,406,444	25,992,304	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	13,982,752	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,291,648	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-12,880,488	117,166,460	5.00
7.00	00700	OPERATION OF PLANT	-39,415	17,784,509	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-18,064	1,016,644	8.00
9.00	00900	HOUSEKEEPING	-180	4,242,873	9.00
10.00	01000	DIETARY	-1,238,799	1,831,877	10.00
11.00	01100	CAFETERIA	-376,755	2,817,198	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	-32,660	-10,071	12.00
13.00	01300	NURSING ADMINISTRATION	-196,736	7,704,107	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-39,678	3,756,405	14.00
15.00	01500	PHARMACY	-32,054	5,727,786	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,123	923,376	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	1,822,721	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	-28,564	486,613	22.00
22.01	02201	EMS PARAMEDICAL PROGRAM	0	0	22.01
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,369	21,277,359	30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,551,514	31.00
43.00	04300	NURSERY	-58	2,239,819	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-5,429	22,163,730	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-1,428	3,948,291	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-136,270	12,165,932	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-7,503	2,609,945	55.00
57.00	05700	CT SCAN	0	1,636,389	57.00
58.00	05800	MRI	35,621	3,559,620	58.00
59.00	05900	CARDIAC CATHETERIZATION	-20,984	2,862,945	59.00
60.00	06000	LABORATORY	-348,675	10,863,725	60.00
65.00	06500	RESPIRATORY THERAPY	-180	2,012,033	65.00
66.00	06600	PHYSICAL THERAPY	-1,662	2,479,191	66.00
68.00	06800	SPEECH PATHOLOGY	-23	1,334,154	68.00
69.00	06900	ELECTROCARDIOLOGY	-21,336	1,102,689	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	585,308	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,082,313	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,596,789	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	41,886,557	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	-5,883	847,839	76.97
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OP PEDS ONC CLINIC	-1,298	2,399,050	90.01
90.02	09002	WOUND CLINIC	-1,406	1,612,770	90.02
91.00	09100	EMERGENCY	-4,670	9,055,634	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	2,983,240	92.01
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	-1,374,344	1,618,155	101.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-11,374,969	378,012,193	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	134,634	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,409,781	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-11,374,969	382,556,608	200.00

RECLASSIFICATIONS

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019

Worksheet A-6

Date/Time Prepared:
1/29/2020 12:25 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
A - MED SUPPLY & IMPLANT RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	6,082,313		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	9,596,789		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
TOTALS			0	15,679,102		
B - SALARY RECLASSSED TO NON SALARY						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,100		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33,635		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	80,790		3.00
4.00	OPERATION OF PLANT	7.00	0	11,455		4.00
5.00	NURSING ADMINISTRATION	13.00	1,451	60,680		5.00
6.00	NURSING ADMINISTRATION	13.00	9,600	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	69,864	389,595		7.00
8.00	CARDIAC CATHETERIZATION	59.00	98,868	12,976		8.00
9.00	RESPIRATORY THERAPY	65.00	155,394	896		9.00
10.00	PHYSICAL THERAPY	66.00	61,740	17,815		10.00
11.00	ELECTROENCEPHALOGRAPHY	70.00	87,900	50,686		11.00
12.00	CARDIAC REHABILITATION	76.97	732	5,319		12.00
13.00	EMERGENCY	91.00	1,101	0		13.00
TOTALS			486,650	665,947		
C - DRUG RECLASS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	41,886,557		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
TOTALS			0	41,886,557		
D - ADMINISTRATIVE RADIOLOGY RECLASS						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	546,592	187,605		1.00
2.00	CT SCAN	57.00	239,214	82,105		2.00
3.00	MRI	58.00	316,909	108,772		3.00
4.00	PHYSICAL THERAPY	66.00	15,985	5,486		4.00
5.00	ELECTROENCEPHALOGRAPHY	70.00	7,792	2,674		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
TOTALS			1,126,492	386,642		
E - EMS PARAMEDICAL RECLASS						
1.00		0.00	0	0		1.00
TOTALS			0	0		
F - DEPRECIATION TRU UP TO MEDICARE						
1.00	OPERATION OF PLANT	7.00	0	1,081,361		1.00
TOTALS			0	1,081,361		
H - NURSERY RECLASS						
1.00	NURSERY	43.00	288,450	104,974		1.00
TOTALS			288,450	104,974		

RECLASSIFICATIONS

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019

Worksheet A-6

Date/Time Prepared:
1/29/2020 12:25 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	J - DIETARY RECLASS					
1.00	CAFETERIA	11.00	0	2,421,664		1.00
	TOTALS		0	2,421,664		
500.00	Grand Total: Increases		1,901,592	62,226,247		500.00

RECLASSIFICATIONS

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019

Worksheet A-6

Date/Time Prepared:
1/29/2020 12:25 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - MED SUPPLY & IMPLANT RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	0	11,685	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	3,203	0		2.00
3.00	NURSERY	43.00	0	77	0		3.00
4.00	OPERATING ROOM	50.00	0	4,692,191	0		4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	0	31,039	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	17,785	0		6.00
7.00	CT SCAN	57.00	0	681	0		7.00
8.00	CARDIAC CATHETERIZATION	59.00	0	1,218,737	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	26,946	0		9.00
10.00	SPEECH PATHOLOGY	68.00	0	65,023	0		10.00
11.00	ELECTROENCEPHALOGRAPHY	70.00	0	529	0		11.00
12.00	OP PEDS ONC CLINIC	90.01	0	5,380	0		12.00
13.00	WOUND CLINIC	90.02	0	1,291	0		13.00
14.00	EMERGENCY	91.00	0	7,903	0		14.00
15.00	HOME HEALTH AGENCY	101.00	0	112	0		15.00
16.00	OPERATING ROOM	50.00	0	7,886,477	0		16.00
17.00	CARDIAC CATHETERIZATION	59.00	0	1,708,376	0		17.00
18.00	WOUND CLINIC	90.02	0	1,667	0		18.00
	TOTALS		0	15,679,102			
	B - SALARY RECLASSED TO NON SALARY						
1.00	ADMINISTRATIVE & GENERAL	5.00	2,100	0	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	33,635	0		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	80,790	0		3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	11,455	0		4.00
5.00	ADMINISTRATIVE & GENERAL	5.00	1,451	60,680	0		5.00
6.00	ADMINISTRATIVE & GENERAL	5.00	9,600	0	0		6.00
7.00	ADMINISTRATIVE & GENERAL	5.00	69,864	389,595	0		7.00
8.00	ADMINISTRATIVE & GENERAL	5.00	98,868	12,976	0		8.00
9.00	ADMINISTRATIVE & GENERAL	5.00	155,394	896	0		9.00
10.00	ADMINISTRATIVE & GENERAL	5.00	61,740	17,815	0		10.00
11.00	ADMINISTRATIVE & GENERAL	5.00	87,900	50,686	0		11.00
12.00	ADMINISTRATIVE & GENERAL	5.00	732	5,319	0		12.00
13.00	ADMINISTRATIVE & GENERAL	5.00	1,101	0	0		13.00
	TOTALS		488,750	663,847			
	C - DRUG RECLASS						
1.00		0.00	0	0	0		1.00
2.00	PHARMACY	15.00	0	41,855,159	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	191	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	77	0		4.00
5.00	OPERATING ROOM	50.00	0	30,122	0		5.00
6.00	DELIVERY ROOM & LABOR ROOM	52.00	0	68	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	44	0		7.00
8.00	CT SCAN	57.00	0	77	0		8.00
9.00	MRI	58.00	0	91	0		9.00
10.00	CARDIAC CATHETERIZATION	59.00	0	182	0		10.00
11.00	LABORATORY	60.00	0	73	0		11.00
12.00	OP PEDS ONC CLINIC	90.01	0	138	0		12.00
13.00	WOUND CLINIC	90.02	0	122	0		13.00
14.00	EMERGENCY	91.00	0	210	0		14.00
15.00	OBSERVATION BEDS (DISTINCT PART)	92.01	0	3	0		15.00
	TOTALS		0	41,886,557			
	D - ADMINISTRATIVE RADIOLOGY RECLASS						
1.00		0.00	0	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	ADMINISTRATIVE & GENERAL	5.00	1,126,492	0	0		6.00
7.00	ADMINISTRATIVE & GENERAL	5.00	0	386,642	0		7.00
	TOTALS		1,126,492	386,642			
	E - EMS PARAMEDICAL RECLASS						
1.00		0.00	0	0	0		1.00
	TOTALS		0	0			
	F - DEPRECIATION TRU UP TO MEDICARE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,081,361	9		1.00
	TOTALS		0	1,081,361			
	H - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	288,450	104,974	0		1.00
	TOTALS		288,450	104,974			

RECLASSIFICATIONS

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019

Worksheet A-6

Date/Time Prepared:
1/29/2020 12:25 pm

	Decreases				wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other		
	6.00	7.00	8.00	9.00	10.00	
	J - DIETARY RECLASS					
1.00	DIETARY	10.00	0	2,421,664	0	1.00
	TOTALS		0	2,421,664		
500.00	Grand Total: Decreases		1,903,692	62,224,147		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019Worksheet A-7
Part I
Date/Time Prepared:
1/29/2020 12:25 pm

		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	52,023,598	0	0	0	0	1.00	
2.00	Land Improvements	0	0	0	0	0	2.00	
3.00	Buildings and Fixtures	548,513,146	19,186,724	0	19,186,724	33,094,077	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	106,606,550	7,792,379	169,437	7,961,816	618,695	5.00	
6.00	Movable Equipment	0	0	0	0	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	707,143,294	26,979,103	169,437	27,148,540	33,712,772	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	707,143,294	26,979,103	169,437	27,148,540	33,712,772	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	52,023,598	0				1.00	
2.00	Land Improvements	0	0				2.00	
3.00	Buildings and Fixtures	534,605,793	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	113,949,671	0				5.00	
6.00	Movable Equipment	0	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	700,579,062	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	700,579,062	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019Worksheet A-7
Part II
Date/Time Prepared:
1/29/2020 12:25 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	21,667,221	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	13,982,752	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	35,649,973	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
		PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2					
1.00	CAP REL COSTS-BLDG & FIXT	0	21,667,221				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	13,982,752				2.00
3.00	Total (sum of lines 1-2)	0	35,649,973				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019Worksheet A-7
Part III
Date/Time Prepared:
1/29/2020 12:25 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	534,605,793	0	534,605,793	0.824302	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	113,949,670	0	113,949,670	0.175698	0	2.00
3.00	Total (sum of lines 1-2)	648,555,463	0	648,555,463	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	25,992,304	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	13,982,752	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	39,975,056	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	25,992,304	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	13,982,752	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	39,975,056	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019

Worksheet A-8

Date/Time Prepared:
1/29/2020 12:25 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	0			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	478,194			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
19.02	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.02
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	0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	0PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	0*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	0*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0	0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	0*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	0ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019

Worksheet A-8

Date/Time Prepared:
1/29/2020 12:25 pm

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	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	ADJ TO MEDICARE BASIS	B	5,406,444	CAP REL COSTS-BLDG & FIXT	1.00	9	33.00
33.01	ACCT 438200 OTHER OPER INCOME HHA	B	-1,365,835	HOME HEALTH AGENCY	101.00	0	33.01
33.02	ACCT 469999 PAYER INTEREST INCOME	B	-147,330	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	ACCT 469999 PAYER INTEREST INCOME	B	-1,363	HOME HEALTH AGENCY	101.00	0	33.03
33.04	ACCT 363001 IDPA CONT ALLOW HAP REV	B	-12,040,895	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	ACCT 410200 VENDING MACHINE DEPOSITS	B	-980	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	ACCT 410200 VENDING MACHINE DEPOSITS	B	-17,044	DIETARY	10.00	0	33.06
33.07	ACCT 410400 DIETARY GUEST TRAYS	B	-15,064	DIETARY	10.00	0	33.07
33.08	ACCT 410000 NUTRITIONALSUPPLEMENT	B	38	EMERGENCY	91.00	0	33.08
33.09	ACCT 415600 APARTMENT RENT	B	-18,550	MAINTENANCE OF PERSONNEL	12.00	0	33.09
33.10	ACCT 438000 NEWSPAPER DELIVERIES	B	1,170	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	ACCT 434401 IC LEASE EMPLOYEES REV	B	-154,111	NURSING ADMINISTRATION	13.00	0	33.11
33.12	ACCT 430850 RESEARCH REVENUE	B	77	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	ACCT 430850 RESEARCH REVENUE	B	-5,056	PHARMACY	15.00	0	33.13
33.14	ACCT 430850 RESEARCH REVENUE	B	-291	OPERATING ROOM	50.00	0	33.14
33.15	ACCT 430850 RESEARCH REVENUE	B	-1,336	RADIOLOGY-DIAGNOSTIC	54.00	0	33.15
33.16	ACCT 430850 RESEARCH REVENUE	B	-1,583	MRI	58.00	0	33.16
33.17	ACCT 430850 RESEARCH REVENUE	B	-995	CARDIAC CATHETERIZATION	59.00	0	33.17
33.19	ACCT 430850 RESEARCH REVENUE	B	-2,144	LABORATORY	60.00	0	33.19
33.20	ACCT 430850 RESEARCH REVENUE	B	-1,695	ELECTROCARDIOLOGY	69.00	0	33.20
34.01	ACCT 432350 IC SHARED SVC HFI LF	B	-15,000	ADMINISTRATIVE & GENERAL	5.00	0	34.01
34.06	ACCT 432350 IC SHARED SVC HFI LF	B	-24,611	ADMINISTRATIVE & GENERAL	5.00	0	34.06
34.07	ACCT 432350 IC SHARED SVC HFI LF	B	-245,901	DIETARY	10.00	0	34.07
34.08	ACCT 432350 IC SHARED SVC HFI LF	B	-825	DIETARY	10.00	0	34.08
34.10	ACCT 432500 IC SHARED SERVICES INCOM	B	-18,064	LAUNDRY & LINEN SERVICE	8.00	0	34.10
34.12	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.12
34.13	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.13
34.14	ACCT 434000 MANUAL FEES	B	-200	MAINTENANCE OF PERSONNEL	12.00	0	34.14
34.15	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.15
34.16	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.16
34.17	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.17
34.18	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.18
36.03	ACCT 434919 CONTRACTED SERVICES REV	B	23,673	ADMINISTRATIVE & GENERAL	5.00	0	36.03
38.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	38.00
38.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	38.01
38.03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	38.03
39.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	39.00
39.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	39.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019

Worksheet A-8

Date/Time Prepared:
1/29/2020 12:25 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A		17/07/2020 12:10 PM	
				To/From Which the Amount is to be Adjusted			
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
39.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	39.02
40.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	40.01
43.00	ACCT DOCTORS PAGER RENTAL	A	-4,754	ADMINISTRATIVE & GENERAL	5.00	0	43.00
43.01	EXCLUDED COST	A	-386,672	ADMINISTRATIVE & GENERAL	5.00	0	43.01
43.02	EXCLUDED COST	A	-10,051	OPERATION OF PLANT	7.00	0	43.02
43.03	EXCLUDED COST	A	-9,124	DIETARY	10.00	0	43.03
43.04	EXCLUDED COST	A	-279	CAFETERIA	11.00	0	43.04
43.05	EXCLUDED COST	A	-39,070	NURSING ADMINISTRATION	13.00	0	43.05
43.06	EXCLUDED COST	A	-39,678	CENTRAL SERVICES & SUPPLY	14.00	0	43.06
43.07	EXCLUDED COST	A	-756	PHARMACY	15.00	0	43.07
43.08	EXCLUDED COST	A	-28,564	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	43.08
43.09	EXCLUDED COST	A	-1,369	ADULTS & PEDIATRICS	30.00	0	43.09
43.10	EXCLUDED COST	A	-58	NURSERY	43.00	0	43.10
43.11	EXCLUDED COST	A	-4,594	OPERATING ROOM	50.00	0	43.11
43.12	EXCLUDED COST	A	-413	DELIVERY ROOM & LABOR ROOM	52.00	0	43.12
43.13	EXCLUDED COST	A	-752	RADIOLOGY-DIAGNOSTIC	54.00	0	43.13
43.14	EXCLUDED COST	A	-7,503	RADIOLOGY-THERAPEUTIC	55.00	0	43.14
43.15	EXCLUDED COST	A	-1,514	MRI	58.00	0	43.15
43.16	EXCLUDED COST	A	-19,989	CARDIAC CATHETERIZATION	59.00	0	43.16
43.17	EXCLUDED COST	A	-8,511	LABORATORY	60.00	0	43.17
43.18	EXCLUDED COST	A	-180	RESPIRATORY THERAPY	65.00	0	43.18
43.19	EXCLUDED COST	A	-91	PHYSICAL THERAPY	66.00	0	43.19
43.20	EXCLUDED COST	A	-23	SPEECH PATHOLOGY	68.00	0	43.20
43.21	EXCLUDED COST	A	-4,148	CARDIAC REHABILITATION	76.97	0	43.21
43.22	EXCLUDED COST	A	-1,298	OP PEDS ONC CLINIC	90.01	0	43.22
43.23	EXCLUDED COST	A	-1,406	WOUND CLINIC	90.02	0	43.23
43.24	EXCLUDED COST	A	-3,836	EMERGENCY	91.00	0	43.24
43.25	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.25
43.26	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.26
43.27	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.27
43.28	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.28
43.29	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.29
43.30	415200 BUILDING RENT NON NMFF NU	B	-13,700	MAINTENANCE OF PERSONNEL	12.00	0	43.30
43.31	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.31
43.32	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.32
43.33	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.33
43.34	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.34
43.35	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.35
43.36	415225 IC BUILDING RENT REVENUE	B	-48,343	RADIOLOGY-DIAGNOSTIC	54.00	0	43.36
43.37	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.37
43.38	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.38
43.39	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.39
43.40	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.40
43.41	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.41
43.42	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.42
43.43	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.43
43.44	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.44

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019

Worksheet A-8

Date/Time Prepared:
1/29/2020 12:25 pm

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	
43.45	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.45
43.46	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.46
43.47	430410 INTERCOMPANY CORPORATE REV	B	-42,053	ADMINISTRATIVE & GENERAL	5.00	0	43.47
43.48	430410 INTERCOMPANY CORPORATE REV	B	-309	OPERATING ROOM	50.00	0	43.48
43.49	430410 INTERCOMPANY CORPORATE REV	B	-235	OPERATING ROOM	50.00	0	43.49
43.50	430410 INTERCOMPANY CORPORATE REV	B	-22,868	RADIOLOGY-DIAGNOSTIC	54.00	0	43.50
43.51	430410 INTERCOMPANY CORPORATE REV	B	-306	LABORATORY	60.00	0	43.51
43.52	430410 INTERCOMPANY CORPORATE REV	B	-307,437	LABORATORY	60.00	0	43.52
43.53	430410 INTERCOMPANY CORPORATE REV	B	-1,402	LABORATORY	60.00	0	43.53
43.54	430410 INTERCOMPANY CORPORATE REV	B	-25,109	LABORATORY	60.00	0	43.54
43.55	430410 INTERCOMPANY CORPORATE REV	B	-4,394	LABORATORY	60.00	0	43.55
43.56	430800 CORPORATE BILLING REVENUE	B	-568	ADMINISTRATIVE & GENERAL	5.00	0	43.56
43.57	430800 CORPORATE BILLING REVENUE	B	-4,460	MRI	58.00	0	43.57
43.58	430800 CORPORATE BILLING REVENUE	B	-1,429	RADIOLOGY-DIAGNOSTIC	54.00	0	43.58
43.59	430800 CORPORATE BILLING REVENUE	B	13,390	LABORATORY	60.00	0	43.59
43.60	430800 CORPORATE BILLING REVENUE	B	-1,674	LABORATORY	60.00	0	43.60
43.61	430800 CORPORATE BILLING REVENUE	B	-4,889	LABORATORY	60.00	0	43.61
43.62	430800 CORPORATE BILLING REVENUE	B	-342	LABORATORY	60.00	0	43.62
43.63	430800 CORPORATE BILLING REVENUE	B	-5,400	RADIOLOGY-DIAGNOSTIC	54.00	0	43.63
43.64	430800 CORPORATE BILLING REVENUE	B	-56,143	RADIOLOGY-DIAGNOSTIC	54.00	0	43.64
43.65	430800 CORPORATE BILLING REVENUE	B	43,178	MRI	58.00	0	43.65
43.66	430800 CORPORATE BILLING REVENUE	B	-19,641	ELECTROCARDIOLOGY	69.00	0	43.66
43.67	430800 CORPORATE BILLING REVENUE	B	-5,857	LABORATORY	60.00	0	43.67
43.68	431000 CORPORATE BILLING ADJUST	B	-48,913	ADMINISTRATIVE & GENERAL	5.00	0	43.68
43.69	438200 OTHER OPERATING INCOME CC3010	A	-3,837	ADMINISTRATIVE & GENERAL	5.00	0	43.69
43.70	438200 OTHER OPERATING INCOME CC3016	A	-980	ADMINISTRATIVE & GENERAL	5.00	0	43.70
43.71	438200 OTHER OPERATING INCOME CC3046	A	-1,158	ADMINISTRATIVE & GENERAL	5.00	0	43.71
43.72	438200 OTHER OPERATING INCOME CC3075	A	-260	ADMINISTRATIVE & GENERAL	5.00	0	43.72
43.73	438200 OTHER OPERATING INCOME CC3135	A	-29,364	OPERATION OF PLANT	7.00	0	43.73
43.74	438200 OTHER OPERATING INCOME CC3211	A	-3,555	NURSING ADMINISTRATION	13.00	0	43.74
43.75	438200 OTHER OPERATING INCOME CC3275	A	-1,735	CARDIAC REHABILITATION	76.97	0	43.75
43.76	438200 OTHER OPERATING INCOME CC3290	A	-872	EMERGENCY	91.00	0	43.76
43.77	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.77
43.78	438200 OTHER OPERATING INCOME CC3324	A	-1,015	DELIVERY ROOM & LABOR ROOM	52.00	0	43.78
43.79	438200 OTHER OPERATING INCOME CC3341	A	-3,500	ADMINISTRATIVE & GENERAL	5.00	0	43.79

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019

Worksheet A-8

Date/Time Prepared:
1/29/2020 12:25 pm

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	
43.80	438200 OTHER OPERATING INCOME CC3374	A	-484	PHYSICAL THERAPY	66.00	0	43.80
43.81	438200 OTHER OPERATING INCOME CC3376	A	-45	PHYSICAL THERAPY	66.00	0	43.81
43.82	438200 OTHER OPERATING INCOME CC3390	A	-26,242	PHARMACY	15.00	0	43.82
43.83	438200 OTHER OPERATING INCOME CC3460	A	-483	PHYSICAL THERAPY	66.00	0	43.83
43.84	438200 OTHER OPERATING INCOME CC3570	A	-559	PHYSICAL THERAPY	66.00	0	43.84
43.85	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0	43.85
43.86	438200 OTHER OPERATING INCOME CC3723	A	-210	MAINTENANCE OF PERSONNEL	12.00	0	43.86
43.87	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.87
43.88	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.88
43.89	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.89
43.90	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.90
43.91	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.91
43.92	411800 OTHER FOOD SERVICE INCOME	A	-950,841	DIETARY	10.00	0	43.92
43.93	411800 OTHER FOOD SERVICE INCOME	A	-186,282	CAFETERIA	11.00	0	43.93
43.94	411800 OTHER FOOD SERVICE INCOME	A	-190,194	CAFETERIA	11.00	0	43.94
43.95	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.95
43.96	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.96
43.97	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.97
43.98	EXCLUDED COST	A	-180	HOUSEKEEPING	9.00	0	43.98
43.99	EXCLUDED COST	A	-1,123	MEDICAL RECORDS & LIBRARY	16.00	0	43.99
44.00	EXCLUDED COST	A	-7,146	HOME HEALTH AGENCY	101.00	0	44.00
44.01	EXCL ACCT 820005 FUND IC SHARED MISC	A	-11,950	ADMINISTRATIVE & GENERAL	5.00	0	44.01
44.02	EXCL ACCT 815350 DONOR REST FUND EXP	A	-49,636	ADMINISTRATIVE & GENERAL	5.00	0	44.02
44.03	EXCL CC3016 ACCT 615201 NO HOURS	A	-42,500	ADMINISTRATIVE & GENERAL	5.00	0	44.03
44.04	EXCL CC3016 ACCT 615201 NO HOURS	A	-195,000	ADMINISTRATIVE & GENERAL	5.00	0	44.04
44.05	EXCL CC3016 ACCT 615201 NO HOURS	A	-12,272	ADMINISTRATIVE & GENERAL	5.00	0	44.05
44.06	EXCL CC3016 ACCT 615201 NO HOURS	A	-13,193	ADMINISTRATIVE & GENERAL	5.00	0	44.06
44.07	EXCL CC3016 ACCT 615201 NO HOURS	A	-177,728	ADMINISTRATIVE & GENERAL	5.00	0	44.07
44.08	EXCL FUND 7395 ACCT 602200 NO HOURS	A	-2,100	ADMINISTRATIVE & GENERAL	5.00	0	44.08
44.09	EXCL FUND 7395 ACCT 615201 NO HOURS	A	-50,000	ADMINISTRATIVE & GENERAL	5.00	0	44.09
44.10	EXCL FUND 7344 ACCT 615201 NO HOURS	A	-25,277	ADMINISTRATIVE & GENERAL	5.00	0	44.10
44.11	EXCL FUND 7319 ACCT 615201 NO HOURS	A	-62,500	ADMINISTRATIVE & GENERAL	5.00	0	44.11
44.12	EXCL FUND 7319 ACCT 615250 CREDIT	A	1,266	ADMINISTRATIVE & GENERAL	5.00	0	44.12
44.13	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.13
44.14	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.14
44.15	HOSPICE REV OFFSET (PROXY)	B	-21,200	ADMINISTRATIVE & GENERAL	5.00	0	44.15
44.16	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.16

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019

Worksheet A-8

Date/Time Prepared:
1/29/2020 12:25 pm

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	
44.17	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.17
44.18	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.18
44.19	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.19
44.20	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.20
44.21	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.21
44.22	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.22
44.23	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.23
44.24	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.24
44.25	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.25
44.26	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.26
44.27	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.27
44.28	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.28
44.29	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.29
44.30	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.30
44.31	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.31
44.32	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.32
44.33	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.33
44.34	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.34
44.35	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.35
44.36	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.36
44.37	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.37
44.38	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.38
44.39	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.39
44.40	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.40
44.41	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.41
44.42	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.42
44.43	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.43
44.44	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.44
44.45	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.45
44.46	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.46
44.47	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.47
44.48	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.48
44.49	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.49
44.50	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.50
44.51	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.51

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019

Worksheet A-8

Date/Time Prepared:
1/29/2020 12:25 pm

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	
44.52	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.52
44.53	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.53
44.54	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.54
44.55	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.55
44.56	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.56
44.57	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.57
44.58	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.58
44.59	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.59
44.60	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.60
44.61	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.61
44.62	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.62
44.63	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.63
44.64	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.64
44.65	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.65
44.66	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.66
44.67	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.67
44.68	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.68
44.69	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.69
44.70	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.70
44.71	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.71
44.72	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.72
44.73	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.73
44.74	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.74
44.75	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.75
44.76	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.76
44.77	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.77
44.78	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.78
44.79	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.79
44.80	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.80
44.81	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.81
44.82	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.82
44.83	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.83
44.84	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.84
44.85	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.85
44.86	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.86

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019

Worksheet A-8

Date/Time Prepared:
1/29/2020 12:25 pm

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	
44.87	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.87
44.88	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.88
44.89	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.89
44.90	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.90
44.91	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.91
44.92	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.92
44.93	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.93
44.94	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.94
44.95	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.95
44.96	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.96
44.97	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.97
44.98	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.98
44.99	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.99
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-11,374,969				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: 14-0130

Period:
From 09/01/2018
To 08/31/2019

Worksheet A-8-1

Date/Time Prepared:
1/29/2020 12:25 pm

	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	0.00			0	0	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT CHARGE	67,529,280	67,051,087	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	VARIOUS	27,109,013	27,109,013	3.02
3.03	54.00	RADIOLOGY-DIAGNOSTIC	VARIOUS	847,714	847,713	3.03
3.04	55.00	RADIOLOGY-THERAPEUTIC	VARIOUS	30,000	30,000	3.04
3.05	58.00	MRI	VARIOUS	44,379	44,379	3.05
3.06	60.00	LABORATORY	VARIOUS	1,341,698	1,341,698	3.06
3.07	0.00			0	0	3.07
3.08	0.00			0	0	3.08
3.09	0.00			0	0	3.09
3.10	0.00			0	0	3.10
3.11	0.00			0	0	3.11
3.12	0.00			0	0	3.12
3.13	0.00			0	0	3.13
3.14	0.00			0	0	3.14
3.15	0.00			0	0	3.15
3.16	0.00			0	0	3.16
3.17	0.00			0	0	3.17
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			96,902,084	96,423,890	5.00

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

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

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

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

6.00	B	0.00	NM HEALTHCARE	100.00	6.00
7.00	B	0.00	NM HOSPITAL	100.00	7.00
8.00	B	0.00	NM FOUNDATION	100.00	8.00
9.00	B	0.00	NM MEDICAL GROUP	100.00	9.00
9.01	B	0.00	LF HEALTH AND FITNESS INSTITUTE	100.00	9.01
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: 14-0130

Period:
From 09/01/2018
To 08/31/2019

Worksheet A-8-1

Date/Time Prepared:
1/29/2020 12:25 pm

	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	0	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
3.01	478,193	0		3.01
3.02	0	0		3.02
3.03	1	0		3.03
3.04	0	0		3.04
3.05	0	0		3.05
3.06	0	0		3.06
3.07	0	0		3.07
3.08	0	0		3.08
3.09	0	0		3.09
3.10	0	0		3.10
3.11	0	0		3.11
3.12	0	0		3.12
3.13	0	0		3.13
3.14	0	0		3.14
3.15	0	0		3.15
3.16	0	0		3.16
3.17	0	0		3.17
4.00	0	0		4.00
5.00	478,194			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	HEALTHCARE		6.00
7.00	HEALTHCARE		7.00
8.00	HEALTHCARE		8.00
9.00	HEALTHCARE		9.00
9.01	HEALTHCARE		9.01
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.

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019Worksheet B
Part I
Date/Time Prepared:
1/29/2020 12:25 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	25,992,304	25,992,304			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	13,982,752		13,982,752		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,291,648	6,742	0	1,298,390	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	117,166,460	1,147,718	2,041,043	190,880	5.00
7.00	00700	OPERATION OF PLANT	17,784,509	11,814,681	209,900	45,744	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,016,644	32,974	148	2,115	8.00
9.00	00900	HOUSEKEEPING	4,242,873	67,292	4,772	28,019	9.00
10.00	01000	DIETARY	1,831,877	289,924	8,716	1,498	10.00
11.00	01100	CAFETERIA	2,817,198	0	3,384	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	-10,071	0	0	17	12.00
13.00	01300	NURSING ADMINISTRATION	7,704,107	53,753	1,418	74,941	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,756,405	110,067	131,932	14,617	14.00
15.00	01500	PHARMACY	5,727,786	105,407	170,329	37,634	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	923,376	0	0	7,360	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,822,721	0	0	19,096	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	486,613	0	0	735	22.00
22.01	02201	EMS PARAMEDICAL PROGRAM	0	0	0	0	22.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	21,277,359	2,461,463	229,263	197,638	30.00
31.00	03100	INTENSIVE CARE UNIT	4,551,514	298,736	205,378	37,792	31.00
43.00	04300	NURSERY	2,239,819	105,453	9,002	13,837	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	22,163,730	1,701,977	2,613,512	197,595	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,948,291	363,905	163,862	37,792	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,165,932	672,395	3,608,173	13,837	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,609,945	324,252	413,963	23,183	55.00
57.00	05700	CT SCAN	1,636,389	113,427	824,522	10,707	57.00
58.00	05800	MRI	3,559,620	139,900	730,242	26,786	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,862,945	208,206	913,338	19,464	59.00
60.00	06000	LABORATORY	10,863,725	173,177	416,994	49,887	60.00
65.00	06500	RESPIRATORY THERAPY	2,012,033	80,290	57,074	17,435	65.00
66.00	06600	PHYSICAL THERAPY	2,479,191	97,391	32,927	23,867	66.00
68.00	06800	SPEECH PATHOLOGY	1,334,154	42,462	18,913	11,714	68.00
69.00	06900	ELECTROCARDIOLOGY	1,102,689	127,783	68,111	11,212	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	585,308	68,649	27,804	4,044	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,082,313	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,596,789	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	41,886,557	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	847,839	275,834	27,923	8,154	76.97
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OP PEDS ONC CLINIC	2,399,050	685,430	22,965	20,286	90.01
90.02	09002	WOUND CLINIC	1,612,770	147,913	7,140	7,819	90.02
91.00	09100	EMERGENCY	9,055,634	628,030	214,762	107,436	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	2,983,240	164,383	5,304	0	92.01
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	1,618,155	0	3,139	29,064	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	378,012,193	22,509,614	13,185,953	1,292,205	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	134,634	0	357	1,409	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,409,781	3,482,690	796,442	4,776	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	0	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	382,556,608	25,992,304	13,982,752	1,298,390	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
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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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	120,546,101					5.00
7.00	00700	OPERATION OF PLANT	14,206,482	44,061,316				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	500,540	0	1,552,421			8.00
9.00	00900	HOUSEKEEPING	2,066,604	923,554	818,780	8,151,894		9.00
10.00	01000	DIETARY	1,014,524	454,167	0	128,445	3,729,151	10.00
11.00	01100	CAFETERIA	1,342,180	1,606,674	0	34,253	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	191,306	0	17,125	0	12.00
13.00	01300	NURSING ADMINISTRATION	3,727,929	2,171,246	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,909,604	402,369	0	85,628	0	14.00
15.00	01500	PHARMACY	2,874,696	1,432,323	0	51,378	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	442,893	413,984	0	188,384	0	16.00
17.00	01700	SOCIAL SERVICE	0	884,972	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	876,432	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	231,906	0	0	0	0	22.00
22.01	02201	EMS PARAMEDICAL PROGRAM	0	0	0	0	0	22.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,499,308	5,714,873	447,816	4,812,355	2,592,394	30.00
31.00	03100	INTENSIVE CARE UNIT	2,423,714	1,027,417	49,575	385,332	355,538	31.00
43.00	04300	NURSERY	1,126,870	121,619	113,643	119,881	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,694,215	8,243,634	27,976	890,543	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,147,925	1,897,571	33,769	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,832,684	3,140,323	0	205,510	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,604,260	1,299,223	0	0	0	55.00
57.00	05700	CT SCAN	1,230,099	244,305	0	0	0	57.00
58.00	05800	MRI	2,120,657	1,071,472	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,905,289	719,299	0	0	0	59.00
60.00	06000	LABORATORY	5,474,098	2,033,340	0	256,887	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,031,091	46,458	0	77,067	0	65.00
66.00	06600	PHYSICAL THERAPY	1,253,097	2,867,716	6,940	94,192	0	66.00
68.00	06800	SPEECH PATHOLOGY	669,639	1,245,423	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	623,269	379,941	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	326,342	764,021	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,894,281	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,566,651	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,931,805	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	551,869	207,860	3,372	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	1,488,337	864,280	0	402,457	0	90.01
90.02	09002	WOUND CLINIC	844,943	300,776	50,550	0	0	90.02
91.00	09100	EMERGENCY	4,761,309	3,051,412	0	333,954	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1,500,327	328,544	0	0	781,219	92.01
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	785,326	11,214	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	120,481,195	44,061,316	1,552,421	8,083,391	3,729,151	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	64,906	0	0	68,503	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	120,546,101	44,061,316	1,552,421	8,151,894	3,729,151	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	5,803,689					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	128	198,505				12.00
13.00	01300	NURSING ADMINISTRATION	331,800	0	14,065,194			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	131,348	0	0	6,541,970		14.00
15.00	01500	PHARMACY	167,644	0	0	0	10,567,197	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	52,872	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	7,240	0	0	0	0	22.00
22.01	02201	EMS PARAMEDICAL PROGRAM	0	0	0	0	0	22.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,243,457	0	4,372,718	23,663	12,755	30.00
31.00	03100	INTENSIVE CARE UNIT	198,207	0	1,001,416	11,385	6,702	31.00
43.00	04300	NURSERY	64,453	0	395,844	339	28	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	802,556	0	2,858,238	974,922	29,821	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	188,189	0	794,164	25,383	3,755	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	492,813	0	138,580	122,972	2,711	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	104,858	0	184,006	868	1	55.00
57.00	05700	CT SCAN	53,476	0	14,439	39,464	954	57.00
58.00	05800	MRI	152,401	0	10,777	51,451	1,153	58.00
59.00	05900	CARDIAC CATHETERIZATION	97,404	0	280,823	104,613	2,686	59.00
60.00	06000	LABORATORY	332,928	49,626	0	507,488	3,157	60.00
65.00	06500	RESPIRATORY THERAPY	102,256	0	0	12,468	66	65.00
66.00	06600	PHYSICAL THERAPY	123,436	49,626	296	52	0	66.00
68.00	06800	SPEECH PATHOLOGY	71,734	0	0	11	0	68.00
69.00	06900	ELECTROCARDIOLOGY	59,825	0	0	226	47	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	17,938	0	0	378	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,413,445	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,196,553	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	10,491,307	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	44,512	0	144,230	174	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	125,759	0	581,525	3,364	3,022	90.01
90.02	09002	WOUND CLINIC	42,014	0	165,487	12,701	682	90.02
91.00	09100	EMERGENCY	611,846	99,253	2,484,488	31,837	8,349	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	10	0	92.01
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	143,091	0	481,796	7,472	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,764,185	198,505	13,908,827	6,541,239	10,567,196	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,099	0	41,729	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	33,405	0	0	18	0	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	114,638	713	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,803,689	198,505	14,065,194	6,541,970	10,567,197	202.00

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			INTERNS & RESIDENTS					
Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	EMS PARAMEDICAL PROGRAM	
			16.00	17.00	21.00	22.00	22.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,028,869					16.00
17.00	01700	SOCIAL SERVICE	0	884,972				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	2,718,249			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		726,494		22.00
22.01	02201	EMS PARAMEDICAL PROGRAM	0	0			0	22.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	120,844	884,972	2,718,249	726,494	0	30.00
31.00	03100	INTENSIVE CARE UNIT	26,235	0	0	0	0	31.00
43.00	04300	NURSERY	5,235	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	315,804	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	32,910	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	184,409	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	60,409	0	0	0	0	55.00
57.00	05700	CT SCAN	80,502	0	0	0	0	57.00
58.00	05800	MRI	106,855	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	48,038	0	0	0	0	59.00
60.00	06000	LABORATORY	203,189	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	26,435	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	15,984	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	5,375	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	53,285	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,760	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	98,282	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72,797	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	337,321	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	2,347	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	16,901	0	0	0	0	90.01
90.02	09002	WOUND CLINIC	10,424	0	0	0	0	90.02
91.00	09100	EMERGENCY	181,029	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	16,463	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	4,036	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,028,869	884,972	2,718,249	726,494	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments			0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	2,028,869	884,972	2,718,249	726,494	0	202.00

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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
22.01	02201	EMS PARAMEDICAL PROGRAM				22.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	59,335,621	-3,444,743	55,890,878	30.00
31.00	03100	INTENSIVE CARE UNIT	10,578,941	0	10,578,941	31.00
43.00	04300	NURSERY	4,316,023	0	4,316,023	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	53,514,523	0	53,514,523	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,637,516	0	9,637,516	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,580,339	0	28,580,339	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,624,968	0	6,624,968	55.00
57.00	05700	CT SCAN	4,248,284	0	4,248,284	57.00
58.00	05800	MRI	7,971,314	0	7,971,314	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,162,105	0	7,162,105	59.00
60.00	06000	LABORATORY	20,364,496	0	20,364,496	60.00
65.00	06500	RESPIRATORY THERAPY	3,462,673	0	3,462,673	65.00
66.00	06600	PHYSICAL THERAPY	7,044,715	0	7,044,715	66.00
68.00	06800	SPEECH PATHOLOGY	3,399,425	0	3,399,425	68.00
69.00	06900	ELECTROCARDIOLOGY	2,426,388	0	2,426,388	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,798,244	0	1,798,244	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,488,321	0	11,488,321	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,432,790	0	16,432,790	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	72,646,990	0	72,646,990	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	2,114,114	0	2,114,114	76.97
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	6,613,376	0	6,613,376	90.01
90.02	09002	WOUND CLINIC	3,203,219	0	3,203,219	90.02
91.00	09100	EMERGENCY	21,569,339	0	21,569,339	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	5,779,490	0	5,779,490	92.01
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,083,293	0	3,083,293	101.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	373,396,507	-3,444,743	369,951,764	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	317,638	0	317,638	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,727,112	0	8,727,112	192.00
194.00	07950	HEALTH & FITNESS CENTER	115,351	0	115,351	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	194.01
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	382,556,608	-3,444,743	379,111,865	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0130

Period:
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,742	0	6,742	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,404,239	1,147,718	2,041,043	13,593,000	996 5.00
7.00	00700	OPERATION OF PLANT	24,936	11,814,681	209,900	12,049,517	239 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	32,974	148	33,122	11 8.00
9.00	00900	HOUSEKEEPING	0	67,292	4,772	72,064	146 9.00
10.00	01000	DIETARY	0	289,924	8,716	298,640	8 10.00
11.00	01100	CAFETERIA	0	0	3,384	3,384	0 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	0	53,753	1,418	55,171	391 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	376,551	110,067	131,932	618,550	76 14.00
15.00	01500	PHARMACY	0	105,407	170,329	275,736	196 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	38 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0 17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	100 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	4 22.00
22.01	02201	EMS PARAMEDICAL PROGRAM	0	0	0	0	0 22.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	2,461,463	229,263	2,690,726	998 30.00
31.00	03100	INTENSIVE CARE UNIT	0	298,736	205,378	504,114	197 31.00
43.00	04300	NURSERY	0	105,453	9,002	114,455	72 43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0 45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	900	1,701,977	2,613,512	4,316,389	1,031 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	769	363,905	163,862	528,536	197 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	672,395	3,608,173	4,280,568	72 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	324,252	413,963	738,215	121 55.00
57.00	05700	CT SCAN	0	113,427	824,522	937,949	56 57.00
58.00	05800	MRI	0	139,900	730,242	870,142	140 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	208,206	913,338	1,121,544	102 59.00
60.00	06000	LABORATORY	0	173,177	416,994	590,171	260 60.00
65.00	06500	RESPIRATORY THERAPY	0	80,290	57,074	137,364	91 65.00
66.00	06600	PHYSICAL THERAPY	0	97,391	32,927	130,318	125 66.00
68.00	06800	SPEECH PATHOLOGY	0	42,462	18,913	61,375	61 68.00
69.00	06900	ELECTROCARDIOLOGY	0	127,783	68,111	195,894	58 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	68,649	27,804	96,453	21 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0 74.00
76.97	07697	CARDIAC REHABILITATION	0	275,834	27,923	303,757	43 76.97
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OP PEDS ONC CLINIC	11,400	685,430	22,965	719,795	106 90.01
90.02	09002	WOUND CLINIC	0	147,913	7,140	155,053	41 90.02
91.00	09100	EMERGENCY	0	628,030	214,762	842,792	561 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	0 92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	164,383	5,304	169,687	0 92.01
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	3,139	3,139	152 101.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,818,795	22,509,614	13,185,953	46,514,362	6,710 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	357	357	7 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,482,690	796,442	4,279,132	25 192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	0	0	0 194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0 194.01
200.00		Cross Foot Adjustments				0	0 200.00
201.00		Negative Cost Centers		0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	10,818,795	25,992,304	13,982,752	50,793,851	6,742 202.00

ALLOCATION OF CAPITAL RELATED COSTS

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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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,593,996					5.00
7.00	00700	OPERATION OF PLANT	1,602,070	13,651,826				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	56,446	0	89,579			8.00
9.00	00900	HOUSEKEEPING	233,052	286,151	47,245	638,658		9.00
10.00	01000	DIETARY	114,408	140,718	0	10,063	563,837	10.00
11.00	01100	CAFETERIA	151,358	497,807	0	2,684	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	59,274	0	1,342	0	12.00
13.00	01300	NURSING ADMINISTRATION	420,400	672,732	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	215,347	124,669	0	6,709	0	14.00
15.00	01500	PHARMACY	324,181	443,787	0	4,025	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	49,945	128,268	0	14,759	0	16.00
17.00	01700	SOCIAL SERVICE	0	274,197	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	98,836	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	26,152	0	0	0	0	22.00
22.01	02201	EMS PARAMEDICAL PROGRAM	0	0	0	0	0	22.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,296,781	1,770,679	25,840	377,021	391,963	30.00
31.00	03100	INTENSIVE CARE UNIT	273,323	318,332	2,861	30,189	53,756	31.00
43.00	04300	NURSERY	127,078	37,682	6,558	9,392	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,431,531	2,554,182	1,614	69,769	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	242,222	587,938	1,949	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	883,295	972,988	0	16,101	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	180,913	402,547	0	0	0	55.00
57.00	05700	CT SCAN	138,719	75,695	0	0	0	57.00
58.00	05800	MRI	239,147	331,982	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	214,860	222,865	0	0	0	59.00
60.00	06000	LABORATORY	617,316	630,004	0	20,126	0	60.00
65.00	06500	RESPIRATORY THERAPY	116,277	14,394	0	6,038	0	65.00
66.00	06600	PHYSICAL THERAPY	141,312	888,525	400	7,379	0	66.00
68.00	06800	SPEECH PATHOLOGY	75,515	385,878	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	70,286	117,720	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	36,802	236,722	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	326,389	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	514,983	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,247,684	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	62,235	64,403	195	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	167,840	267,786	0	31,530	0	90.01
90.02	09002	WOUND CLINIC	95,285	93,191	2,917	0	0	90.02
91.00	09100	EMERGENCY	536,935	945,440	0	26,164	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	169,192	101,795	0	0	118,118	92.01
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	88,562	3,475	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,586,677	13,651,826	89,579	633,291	563,837	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,319	0	0	5,367	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	13,593,996	13,651,826	89,579	638,658	563,837	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0130

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Cost Center Description			CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	655,233					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	14	57,702				12.00
13.00	01300	NURSING ADMINISTRATION	37,460	0	1,186,154			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14,829	0	0	980,180		14.00
15.00	01500	PHARMACY	18,927	0	0	0	1,066,852	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,969	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	817	0	0	0	0	22.00
22.01	02201	EMS PARAMEDICAL PROGRAM	0	0	0	0	0	22.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	140,389	0	368,762	3,545	1,288	30.00
31.00	03100	INTENSIVE CARE UNIT	22,377	0	84,452	1,706	677	31.00
43.00	04300	NURSERY	7,277	0	33,383	51	3	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	90,608	0	241,043	146,070	3,011	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	21,246	0	66,974	3,803	379	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	55,638	0	11,687	18,425	274	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	11,838	0	15,518	130	0	55.00
57.00	05700	CT SCAN	6,037	0	1,218	5,913	96	57.00
58.00	05800	MRI	17,206	0	909	7,709	116	58.00
59.00	05900	CARDIAC CATHETERIZATION	10,997	0	23,682	15,674	271	59.00
60.00	06000	LABORATORY	37,587	14,425	0	76,036	319	60.00
65.00	06500	RESPIRATORY THERAPY	11,545	0	0	1,868	7	65.00
66.00	06600	PHYSICAL THERAPY	13,936	14,425	25	8	0	66.00
68.00	06800	SPEECH PATHOLOGY	8,099	0	0	2	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6,754	0	0	34	5	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,025	0	0	57	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	361,611	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	329,104	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,059,189	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	5,025	0	12,163	26	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	14,198	0	49,041	504	305	90.01
90.02	09002	WOUND CLINIC	4,743	0	13,956	1,903	69	90.02
91.00	09100	EMERGENCY	69,077	28,852	209,523	4,770	843	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	1	0	92.01
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	16,155	0	40,631	1,120	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	650,773	57,702	1,172,967	980,070	1,066,852	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	689	0	3,519	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,771	0	0	3	0	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	9,668	107	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	2,928	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	655,233	60,630	1,186,154	980,180	1,066,852	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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			INTERNS & RESIDENTS					
Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	EMS PARAMEDICAL PROGRAM	
			16.00	17.00	21.00	22.00	22.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	198,979					16.00
17.00	01700	SOCIAL SERVICE	0	274,197				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	98,936			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		26,973		22.00
22.01	02201	EMS PARAMEDICAL PROGRAM	0	0			0	22.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,886	274,197				30.00
31.00	03100	INTENSIVE CARE UNIT	2,580	0				31.00
43.00	04300	NURSERY	515	0				43.00
44.00	04400	SKILLED NURSING FACILITY	0	0				44.00
45.00	04500	NURSING FACILITY	0	0				45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	31,063	0				50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,237	0				52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,139	0				54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,942	0				55.00
57.00	05700	CT SCAN	7,918	0				57.00
58.00	05800	MRI	10,510	0				58.00
59.00	05900	CARDIAC CATHETERIZATION	4,725	0				59.00
60.00	06000	LABORATORY	19,986	0				60.00
65.00	06500	RESPIRATORY THERAPY	2,600	0				65.00
66.00	06600	PHYSICAL THERAPY	1,572	0				66.00
68.00	06800	SPEECH PATHOLOGY	529	0				68.00
69.00	06900	ELECTROCARDIOLOGY	5,241	0				69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	370	0				70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,667	0				71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,160	0				72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,599	0				73.00
74.00	07400	RENAL DIALYSIS	0	0				74.00
76.97	07697	CARDIAC REHABILITATION	231	0				76.97
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	1,662	0				90.01
90.02	09002	WOUND CLINIC	1,025	0				90.02
91.00	09100	EMERGENCY	17,806	0				91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1,619	0				92.01
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	397	0				101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	198,979	274,197	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0				192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0				194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0				194.01
200.00		Cross Foot Adjustments			98,936	26,973	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	198,979	274,197	98,936	26,973	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019Worksheet B
Part II
Date/Time Prepared:
1/29/2020 12:25 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
22.01	02201	EMS PARAMEDICAL PROGRAM				22.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,354,075	0	7,354,075	30.00
31.00	03100	INTENSIVE CARE UNIT	1,294,564	0	1,294,564	31.00
43.00	04300	NURSERY	336,466	0	336,466	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,886,311	0	8,886,311	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,456,481	0	1,456,481	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,257,187	0	6,257,187	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,355,224	0	1,355,224	55.00
57.00	05700	CT SCAN	1,173,601	0	1,173,601	57.00
58.00	05800	MRI	1,477,861	0	1,477,861	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,614,720	0	1,614,720	59.00
60.00	06000	LABORATORY	2,006,230	0	2,006,230	60.00
65.00	06500	RESPIRATORY THERAPY	290,184	0	290,184	65.00
66.00	06600	PHYSICAL THERAPY	1,198,025	0	1,198,025	66.00
68.00	06800	SPEECH PATHOLOGY	531,459	0	531,459	68.00
69.00	06900	ELECTROCARDIOLOGY	395,992	0	395,992	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	372,450	0	372,450	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	697,667	0	697,667	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	851,247	0	851,247	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,339,472	0	3,339,472	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	448,078	0	448,078	76.97
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	1,252,767	0	1,252,767	90.01
90.02	09002	WOUND CLINIC	368,183	0	368,183	90.02
91.00	09100	EMERGENCY	2,682,763	0	2,682,763	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	560,412	0	560,412	92.01
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	153,631	0	153,631	101.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	46,355,050	0	46,355,050	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,258	0	17,258	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,282,931	0	4,282,931	192.00
194.00	07950	HEALTH & FITNESS CENTER	9,775	0	9,775	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	194.01
200.00		Cross Foot Adjustments	125,909	0	125,909	200.00
201.00		Negative Cost Centers	2,928	0	2,928	201.00
202.00		TOTAL (sum lines 118 through 201)	50,793,851	0	50,793,851	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019

Worksheet B-1

Date/Time Prepared:
1/29/2020 12:25 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			BLDG & FIXT (DV SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	28,878,365					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		14,157,323				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,491	0	102,636,256			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,275,156	2,066,525	15,089,335	-120,546,101	253,326,872	5.00
7.00	00700	OPERATION OF PLANT	13,126,518	212,521	3,616,148	0	29,854,834	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	36,635	150	167,204	0	1,051,881	8.00
9.00	00900	HOUSEKEEPING	74,764	4,832	2,214,944	0	4,342,956	9.00
10.00	01000	DIETARY	322,116	8,825	118,438	0	2,132,015	10.00
11.00	01100	CAFETERIA	0	3,426	0	0	2,820,582	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	1,321	10,054	0	12.00
13.00	01300	NURSING ADMINISTRATION	59,722	1,436	5,924,212	0	7,834,219	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	122,288	133,579	1,155,515	0	4,013,021	14.00
15.00	01500	PHARMACY	117,111	172,456	2,974,994	0	6,041,156	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	581,779	0	930,736	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	1,509,547	0	1,841,817	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	58,116	0	487,348	22.00
22.01	02201	EMS PARAMEDICAL PROGRAM	0	0	0	0	0	22.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,734,773	232,125	15,620,182	0	24,165,723	30.00
31.00	03100	INTENSIVE CARE UNIT	331,906	207,942	2,987,527	0	5,093,420	31.00
43.00	04300	NURSERY	117,162	9,114	1,093,852	0	2,368,111	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,890,957	2,646,142	15,620,182	0	26,676,814	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	404,312	165,908	2,987,527	0	4,513,850	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	747,055	3,653,218	1,093,852	0	16,460,337	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	360,256	419,131	1,832,614	0	3,371,343	55.00
57.00	05700	CT SCAN	126,021	834,816	846,437	0	2,585,045	57.00
58.00	05800	MRI	155,434	739,359	2,117,457	0	4,456,548	58.00
59.00	05900	CARDIAC CATHETERIZATION	231,324	924,741	1,538,683	0	4,003,953	59.00
60.00	06000	LABORATORY	192,406	422,200	3,943,674	0	11,503,783	60.00
65.00	06500	RESPIRATORY THERAPY	89,205	57,787	1,378,281	0	2,166,832	65.00
66.00	06600	PHYSICAL THERAPY	108,205	33,338	1,886,687	0	2,633,376	66.00
68.00	06800	SPEECH PATHOLOGY	47,177	19,149	925,978	0	1,407,243	68.00
69.00	06900	ELECTROCARDIOLOGY	141,972	68,961	886,357	0	1,309,795	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	76,272	28,151	319,697	0	685,805	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	6,082,313	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	9,596,789	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	41,886,557	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	306,461	28,272	644,546	0	1,159,750	76.97
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	761,537	23,252	1,603,632	0	3,127,731	90.01
90.02	09002	WOUND CLINIC	164,337	7,229	618,090	0	1,775,642	90.02
91.00	09100	EMERGENCY	697,764	217,443	8,492,990	0	10,005,862	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	182,635	5,370	0	0	3,152,927	92.01
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	3,178	2,297,575	0	1,650,358	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,008,972	13,350,576	102,147,373	-120,536,047	253,190,472	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	361	111,347	0	136,400	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,869,393	806,386	377,536	-8,693,689	0	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	25,992,304	13,982,752	1,298,390		120,546,101	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.900061	0.987669	0.012650		0.475852	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			6,742		13,593,996	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000066		0.053662	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019

Worksheet B-1

Date/Time Prepared:
1/29/2020 12:25 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			BLDG & FIXT (DV SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
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: 14-0130

Period:
From 09/01/2018
To 08/31/2019

Worksheet B-1

Date/Time Prepared:
1/29/2020 12:25 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	330,047				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,164,923			8.00
9.00	00900	HOUSEKEEPING	6,918	614,405	4,352,197		9.00
10.00	01000	DIETARY	3,402	0	68,575	81,183	10.00
11.00	01100	CAFETERIA	12,035	0	18,287	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	1,433	0	9,143	0	12.00
13.00	01300	NURSING ADMINISTRATION	16,264	0	0	127,407	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,014	0	45,716	50,436	14.00
15.00	01500	PHARMACY	10,729	0	27,430	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,101	0	100,576	0	16.00
17.00	01700	SOCIAL SERVICE	6,629	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
22.01	02201	EMS PARAMEDICAL PROGRAM	0	0	0	0	22.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	42,808	336,037	2,569,258	56,436	30.00
31.00	03100	INTENSIVE CARE UNIT	7,696	37,201	205,724	7,740	31.00
43.00	04300	NURSERY	911	85,277	64,003	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	61,750	20,993	475,450	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,214	25,340	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,523	0	109,719	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	9,732	0	0	0	55.00
57.00	05700	CT SCAN	1,830	0	0	0	57.00
58.00	05800	MRI	8,026	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,388	0	0	0	59.00
60.00	06000	LABORATORY	15,231	0	137,149	0	60.00
65.00	06500	RESPIRATORY THERAPY	348	0	41,145	0	65.00
66.00	06600	PHYSICAL THERAPY	21,481	5,208	50,288	0	66.00
68.00	06800	SPEECH PATHOLOGY	9,329	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,846	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,723	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	1,557	2,530	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OP PEDS ONC CLINIC	6,474	0	214,867	0	90.01
90.02	09002	WOUND CLINIC	2,253	37,932	0	0	90.02
91.00	09100	EMERGENCY	22,857	0	178,294	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	2,461	0	0	17,007	92.01
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	84	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	330,047	1,164,923	4,315,624	81,183	2,213,373
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	36,573	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	0	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	44,061,316	1,552,421	8,151,894	3,729,151	5,803,689
203.00		Unit cost multiplier (Wkst. B, Part I)	133.500126	1.332638	1.873053	45.935122	2.604254
204.00		Cost to be allocated (per Wkst. B, Part II)	13,651,826	89,579	638,658	563,837	655,233
205.00		Unit cost multiplier (Wkst. B, Part II)	41.363279	0.076897	0.146744	6.945259	0.294019
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019

Worksheet B-1

Date/Time Prepared:
1/29/2020 12:25 pm

Cost Center Description			MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
			12.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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
12.00	01200	MAINTENANCE OF PERSONNEL	1,012,080					12.00
13.00	01300	NURSING ADMINISTRATION	0	806,580				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	30,411,629			14.00
15.00	01500	PHARMACY	0	0	0	43,846,148		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	1,848,312,469	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
22.01	02201	EMS PARAMEDICAL PROGRAM	0	0	0	0	0	22.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	250,757	110,001	52,924	110,058,113	30.00
31.00	03100	INTENSIVE CARE UNIT	0	57,427	52,924	27,809	23,893,084	31.00
43.00	04300	NURSERY	0	22,700	1,574	115	4,767,324	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	163,908	4,532,116	123,737	287,617,614	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	45,542	117,998	15,580	29,972,726	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,947	571,661	11,248	167,950,225	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	10,552	4,033	4	55,017,335	55.00
57.00	05700	CT SCAN	0	828	183,455	3,957	73,317,131	57.00
58.00	05800	MRI	0	618	239,178	4,783	97,317,912	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	16,104	486,316	11,144	43,750,644	59.00
60.00	06000	LABORATORY	253,020	0	2,359,157	13,100	185,053,657	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	57,959	272	24,075,194	65.00
66.00	06600	PHYSICAL THERAPY	253,020	17	240	0	14,557,786	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	53	0	4,895,371	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	1,052	193	48,529,208	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	1,757	0	3,424,695	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	11,219,368	0	89,509,976	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	10,211,113	0	66,299,761	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	43,531,265	307,739,755	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	8,271	808	0	2,137,500	76.97
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	0	33,348	15,640	12,539	15,392,856	90.01
90.02	09002	WOUND CLINIC	0	9,490	59,045	2,830	9,493,422	90.02
91.00	09100	EMERGENCY	506,040	142,475	148,001	34,644	164,871,333	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	46	0	14,993,681	92.01
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	27,629	34,735	0	3,676,166	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,012,080	797,613	30,408,230	43,846,144	1,848,312,469	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,393	0	4	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	84	0	0	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	6,574	3,315	0	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	198,505	14,065,194	6,541,970	10,567,197	2,028,869	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.196136	17.438064	0.215114	0.241006	0.001098	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	60,630	1,186,154	980,180	1,066,852	198,979	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.057013	1.470597	0.032230	0.024332	0.000108	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019

Worksheet B-1

Date/Time Prepared:
1/29/2020 12:25 pm

Cost Center Description			MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	12.00	13.00	14.00	15.00	16.00	207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019

Worksheet B-1

Date/Time Prepared:
1/29/2020 12:25 pm

Cost Center Description			INTERNS & RESIDENTS					
			SOCIAL SERVICE (TIME SPENT)	SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	EMS PARAMEDICAL PROGRAM (ASSIGNED TIME)		
			17.00	21.00	22.00	22.01		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	100					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	100				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		100			22.00
22.01	02201	EMS PARAMEDICAL PROGRAM	0			100		22.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	100	100	100	100		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0		31.00
43.00	04300	NURSERY	0	0	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
45.00	04500	NURSING FACILITY	0	0	0	0		45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0		55.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	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
65.00	06500	RESPIRATORY THERAPY	0	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0		74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0		76.97
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	0	0	0	0		90.01
90.02	09002	WOUND CLINIC	0	0	0	0		90.02
91.00	09100	EMERGENCY	0	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0		92.01
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	100	100	100		118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	0	0		194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0		194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	884,972	2,718,249	726,494	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8,849.720000	27,182.490000	7,264.940000	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	274,197	98,936	26,973	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2,741.970000	989.360000	269.730000	0.000000		205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019

Worksheet B-1

Date/Time Prepared:
1/29/2020 12:25 pm

Cost Center Description			INTERNS & RESIDENTS					
			SOCIAL SERVICE (TIME SPENT)	SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	EMS PARAMEDICAL PROGRAM (ASSIGNED TIME)		
			17.00	21.00	22.00	22.01		
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

Worksheet C
Part I
Date/Time Prepared:
1/29/2020 12:25 pm

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COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019Worksheet C
Part I
Date/Time Prepared:
1/29/2020 12:25 pm

			Title XVIII			Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	94,211,827		94,211,827			30.00
31.00	03100	INTENSIVE CARE UNIT	23,893,084		23,893,084			31.00
43.00	04300	NURSERY	4,767,324		4,767,324			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
45.00	04500	NURSING FACILITY	0		0			45.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	77,020,001	210,597,613	287,617,614	0.186061	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	28,202,913	1,769,813	29,972,726	0.321543	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,285,806	152,664,419	167,950,225	0.170171	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	819,671	54,197,664	55,017,335	0.120416	0.000000	55.00
57.00	05700	CT SCAN	23,811,904	49,505,227	73,317,131	0.057944	0.000000	57.00
58.00	05800	MRI	11,521,164	85,796,748	97,317,912	0.081910	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	23,085,014	20,665,630	43,750,644	0.163703	0.000000	59.00
60.00	06000	LABORATORY	66,132,007	118,921,650	185,053,657	0.110046	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	19,298,496	4,776,698	24,075,194	0.143827	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,245	14,555,541	14,557,786	0.483914	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	1,321,695	3,573,676	4,895,371	0.694416	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	14,902,430	33,626,778	48,529,208	0.049999	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	370,695	3,054,000	3,424,695	0.525082	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32,629,785	56,880,191	89,509,976	0.128347	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	40,111,435	26,188,326	66,299,761	0.247856	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,732,939	276,006,816	307,739,755	0.236066	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	4,564	2,132,936	2,137,500	0.989059	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OP PEDS ONC CLINIC	95,079	15,297,777	15,392,856	0.429639	0.000000	90.01
90.02	09002	WOUND CLINIC	50,714	9,442,708	9,493,422	0.337415	0.000000	90.02
91.00	09100	EMERGENCY	28,281,967	136,589,366	164,871,333	0.130825	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,465,492	13,380,794	15,846,286	0.621955	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	5,157,485	9,836,196	14,993,681	0.385462	0.000000	92.01
	OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	3,676,166	3,676,166			101.00
200.00		Subtotal (see instructions)	545,175,736	1,303,136,733	1,848,312,469			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	545,175,736	1,303,136,733	1,848,312,469			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019Worksheet C
Part I
Date/Time Prepared:
1/29/2020 12:25 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.186061		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.321543		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.170171		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.120416		55.00
57.00	05700	CT SCAN	0.057944		57.00
58.00	05800	MRI	0.081910		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.163703		59.00
60.00	06000	LABORATORY	0.110046		60.00
65.00	06500	RESPIRATORY THERAPY	0.143827		65.00
66.00	06600	PHYSICAL THERAPY	0.483914		66.00
68.00	06800	SPEECH PATHOLOGY	0.694416		68.00
69.00	06900	ELECTROCARDIOLOGY	0.049999		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.525082		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.128347		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.247856		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.236066		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.97	07697	CARDIAC REHABILITATION	0.989059		76.97
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OP PEDS ONC CLINIC	0.429639		90.01
90.02	09002	WOUND CLINIC	0.337415		90.02
91.00	09100	EMERGENCY	0.130825		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.621955		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.385462		92.01
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY			101.00
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: 14-0130

Period:
From 09/01/2018
To 08/31/2019Worksheet C
Part I
Date/Time Prepared:
1/29/2020 12:25 pm

			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	55,890,878		55,890,878	0	55,890,878	30.00
31.00	03100	INTENSIVE CARE UNIT	10,578,941		10,578,941	0	10,578,941	31.00
43.00	04300	NURSERY	4,316,023		4,316,023	0	4,316,023	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	53,514,523		53,514,523	0	53,514,523	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,637,516		9,637,516	0	9,637,516	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,580,339		28,580,339	0	28,580,339	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,624,968		6,624,968	0	6,624,968	55.00
57.00	05700	CT SCAN	4,248,284		4,248,284	0	4,248,284	57.00
58.00	05800	MRI	7,971,314		7,971,314	0	7,971,314	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,162,105		7,162,105	0	7,162,105	59.00
60.00	06000	LABORATORY	20,364,496		20,364,496	0	20,364,496	60.00
65.00	06500	RESPIRATORY THERAPY	3,462,673	0	3,462,673	0	3,462,673	65.00
66.00	06600	PHYSICAL THERAPY	7,044,715	0	7,044,715	0	7,044,715	66.00
68.00	06800	SPEECH PATHOLOGY	3,399,425	0	3,399,425	0	3,399,425	68.00
69.00	06900	ELECTROCARDIOLOGY	2,426,388		2,426,388	0	2,426,388	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,798,244		1,798,244	0	1,798,244	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,488,321		11,488,321	0	11,488,321	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,432,790		16,432,790	0	16,432,790	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	72,646,990		72,646,990	0	72,646,990	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	2,114,114		2,114,114	0	2,114,114	76.97
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	6,613,376		6,613,376	0	6,613,376	90.01
90.02	09002	WOUND CLINIC	3,203,219		3,203,219	0	3,203,219	90.02
91.00	09100	EMERGENCY	21,569,339		21,569,339	0	21,569,339	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	9,855,674		9,855,674	0	9,855,674	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	5,779,490		5,779,490	0	5,779,490	92.01
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	3,083,293		3,083,293	0	3,083,293	101.00
200.00		Subtotal (see instructions)	379,807,438	0	379,807,438	0	379,807,438	200.00
201.00		Less Observation Beds	9,855,674		9,855,674	0	9,855,674	201.00
202.00		Total (see instructions)	369,951,764	0	369,951,764	0	369,951,764	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019Worksheet C
Part I
Date/Time Prepared:
1/29/2020 12:25 pm

			Title XIX			Hospital	Cost		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	94,211,827		94,211,827			30.00	
31.00	03100	INTENSIVE CARE UNIT	23,893,084		23,893,084			31.00	
43.00	04300	NURSERY	4,767,324		4,767,324			43.00	
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00	
45.00	04500	NURSING FACILITY	0		0			45.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	77,020,001	210,597,613	287,617,614	0.186061	0.000000	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	28,202,913	1,769,813	29,972,726	0.321543	0.000000	52.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,285,806	152,664,419	167,950,225	0.170171	0.000000	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	819,671	54,197,664	55,017,335	0.120416	0.000000	55.00	
57.00	05700	CT SCAN	23,811,904	49,505,227	73,317,131	0.057944	0.000000	57.00	
58.00	05800	MRI	11,521,164	85,796,748	97,317,912	0.081910	0.000000	58.00	
59.00	05900	CARDIAC CATHETERIZATION	23,085,014	20,665,630	43,750,644	0.163703	0.000000	59.00	
60.00	06000	LABORATORY	66,132,007	118,921,650	185,053,657	0.110046	0.000000	60.00	
65.00	06500	RESPIRATORY THERAPY	19,298,496	4,776,698	24,075,194	0.143827	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	2,245	14,555,541	14,557,786	0.483914	0.000000	66.00	
68.00	06800	SPEECH PATHOLOGY	1,321,695	3,573,676	4,895,371	0.694416	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	14,902,430	33,626,778	48,529,208	0.049999	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	370,695	3,054,000	3,424,695	0.525082	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32,629,785	56,880,191	89,509,976	0.128347	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	40,111,435	26,188,326	66,299,761	0.247856	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	31,732,939	276,006,816	307,739,755	0.236066	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00	
76.97	07697	CARDIAC REHABILITATION	4,564	2,132,936	2,137,500	0.989059	0.000000	76.97	
	OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	95,079	15,297,777	15,392,856	0.429639	0.000000	90.01	
90.02	09002	WOUND CLINIC	50,714	9,442,708	9,493,422	0.337415	0.000000	90.02	
91.00	09100	EMERGENCY	28,281,967	136,589,366	164,871,333	0.130825	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,465,492	13,380,794	15,846,286	0.621955	0.000000	92.00	
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	5,157,485	9,836,196	14,993,681	0.385462	0.000000	92.01	
	OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	3,676,166	3,676,166			101.00	
200.00		Subtotal (see instructions)	545,175,736	1,303,136,733	1,848,312,469			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	545,175,736	1,303,136,733	1,848,312,469			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019Worksheet C
Part I
Date/Time Prepared:
1/29/2020 12:25 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
44.00	04400	SKILLED NURSING FACILITY				44.00
45.00	04500	NURSING FACILITY				45.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	0.000000			90.01
90.02	09002	WOUND CLINIC	0.000000			90.02
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000			92.01
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY				101.00
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: 14-0130

Period:
From 09/01/2018
To 08/31/2019Worksheet D
Part I
Date/Time Prepared:
1/29/2020 12:25 pm

			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	7,354,075	0	7,354,075	30,952	237.60	30.00
31.00	INTENSIVE CARE UNIT	1,294,564		1,294,564	3,622	357.42	31.00
43.00	NURSERY	336,466		336,466	4,497	74.82	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (lines 30 through 199)	8,985,105		8,985,105	39,071		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	10,796	2,565,130				
31.00	INTENSIVE CARE UNIT	2,070	739,859				
43.00	NURSERY	0	0				
44.00	SKILLED NURSING FACILITY	0	0				
45.00	NURSING FACILITY	0	0				
200.00	Total (lines 30 through 199)	12,866	3,304,989				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019Worksheet D
Part II
Date/Time Prepared:
1/29/2020 12:25 pm

Cost Center Description			Title XVIII		Hospital	PPS	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,886,311	287,617,614	0.030896	34,277,050	1,059,024
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,456,481	29,972,726	0.048594	6,811	331
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,257,187	167,950,225	0.037256	7,326,625	272,961
55.00	05500	RADIOLOGY-THERAPEUTIC	1,355,224	55,017,335	0.024633	402,120	9,905
57.00	05700	CT SCAN	1,173,601	73,317,131	0.016007	10,919,068	174,782
58.00	05800	MRI	1,477,861	97,317,912	0.015186	4,574,639	69,470
59.00	05900	CARDIAC CATHETERIZATION	1,614,720	43,750,644	0.036907	10,408,755	384,156
60.00	06000	LABORATORY	2,006,230	185,053,657	0.010841	27,918,969	302,670
65.00	06500	RESPIRATORY THERAPY	290,184	24,075,194	0.012053	10,555,326	127,223
66.00	06600	PHYSICAL THERAPY	1,198,025	14,557,786	0.082294	2,199	181
68.00	06800	SPEECH PATHOLOGY	531,459	4,895,371	0.108564	821,940	89,233
69.00	06900	ELECTROCARDIOLOGY	395,992	48,529,208	0.008160	7,479,686	61,034
70.00	07000	ELECTROENCEPHALOGRAPHY	372,450	3,424,695	0.108754	171,972	18,703
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	697,667	89,509,976	0.007794	13,721,596	106,946
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	851,247	66,299,761	0.012839	20,912,853	268,500
73.00	07300	DRUGS CHARGED TO PATIENTS	3,339,472	307,739,755	0.010852	12,058,137	130,855
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0
76.97	07697	CARDIAC REHABILITATION	448,078	2,137,500	0.209627	3,587	752
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OP PEDS ONC CLINIC	1,252,767	15,392,856	0.081386	94,282	7,673
90.02	09002	WOUND CLINIC	368,183	9,493,422	0.038783	24,572	953
91.00	09100	EMERGENCY	2,682,763	164,871,333	0.016272	13,153,079	214,027
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,296,800	15,846,286	0.081836	2,048,574	167,647
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	560,412	14,993,681	0.037377	278,425	10,407
200.00		Total (lines 50 through 199)	38,513,114	1,721,764,068		177,160,265	3,477,433

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0130		Period: From 09/01/2018 To 08/31/2019		Worksheet D Part III Date/Time Prepared: 1/29/2020 12:25 pm		
					Title XVIII		Hospital		PPS		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost				
			1A	1.00	2A	2.00	3.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00		
43.00	04300	NURSERY	0	0	0	0	0	0	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	44.00		
45.00	04500	NURSING FACILITY	0	0	0	0	0	0	45.00		
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	200.00		
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)		Inpatient Program Days			
			4.00	5.00	6.00	7.00		8.00			
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	30,952	0.00		10,796		30.00	
31.00	03100	INTENSIVE CARE UNIT		0	3,622	0.00		2,070		31.00	
43.00	04300	NURSERY		0	4,497	0.00		0		43.00	
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00		0		44.00	
45.00	04500	NURSING FACILITY		0	0	0.00		0		45.00	
200.00		Total (lines 30 through 199)		0	39,071			12,866		200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)								
			9.00								
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0								30.00
31.00	03100	INTENSIVE CARE UNIT	0								31.00
43.00	04300	NURSERY	0								43.00
44.00	04400	SKILLED NURSING FACILITY	0								44.00
45.00	04500	NURSING FACILITY	0								45.00
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0130		Period: From 09/01/2018 To 08/31/2019		Worksheet D Part IV Date/Time Prepared: 1/29/2020 12:25 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	OP PEDS ONC CLINIC		0	0	0	0	0	90.01
90.02	09002	WOUND CLINIC		0	0	0	0	0	90.02
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)		0	0	0	0	0	92.01
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019

Worksheet D
Part IV
Date/Time Prepared:
1/29/2020 12:25 pm

			Title XVIII		Hospital	PPS		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	287,617,614	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	29,972,726	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	167,950,225	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	55,017,335	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	73,317,131	0.000000	57.00
58.00	05800	MRI	0	0	0	97,317,912	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	43,750,644	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	185,053,657	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	24,075,194	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	14,557,786	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	4,895,371	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	48,529,208	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	3,424,695	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	89,509,976	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	66,299,761	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	307,739,755	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	2,137,500	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OP PEDS ONC CLINIC	0	0	0	15,392,856	0.000000	90.01
90.02	09002	WOUND CLINIC	0	0	0	9,493,422	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	164,871,333	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	15,846,286	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	14,993,681	0.000000	92.01
200.00		Total (lines 50 through 199)	0	0	0	1,721,764,068		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019Worksheet D
Part IV
Date/Time Prepared:
1/29/2020 12:25 pm

Cost Center Description			Title XVIII		Hospital		PPS
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
			9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	34,277,050	0	46,165,574	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	6,811	0	9,177	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	7,326,625	0	38,614,523	0
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	402,120	0	23,286,059	0
57.00	05700	CT SCAN	0.000000	10,919,068	0	13,924,987	0
58.00	05800	MRI	0.000000	4,574,639	0	24,148,363	0
59.00	05900	CARDIAC CATHETERIZATION	0.000000	10,408,755	0	9,512,498	0
60.00	06000	LABORATORY	0.000000	27,918,969	0	22,320,967	0
65.00	06500	RESPIRATORY THERAPY	0.000000	10,555,326	0	1,244,609	0
66.00	06600	PHYSICAL THERAPY	0.000000	2,199	0	241,840	0
68.00	06800	SPEECH PATHOLOGY	0.000000	821,940	0	295,198	0
69.00	06900	ELECTROCARDIOLOGY	0.000000	7,479,686	0	11,071,750	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	171,972	0	977,699	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	13,721,596	0	13,636,602	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	20,912,853	0	6,964,077	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	12,058,137	0	103,532,800	0
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0.000000	3,587	0	1,199,528	0
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OP PEDS ONC CLINIC	0.000000	94,282	0	6,831,961	0
90.02	09002	WOUND CLINIC	0.000000	24,572	0	4,980,193	0
91.00	09100	EMERGENCY	0.000000	13,153,079	0	23,404,131	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	2,048,574	0	4,502,856	0
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	278,425	0	573,137	0
200.00		Total (lines 50 through 199)		177,160,265	0	357,438,529	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019Worksheet D
Part V
Date/Time Prepared:
1/29/2020 12:25 pm

			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	0.186061	46,165,574	0	0	8,589,613	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.321543	9,177	0	0	2,951	52.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.170171	38,614,523	0	0	6,571,072	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0.120416	23,286,059	0	0	2,804,014	55.00	
57.00	05700	CT SCAN	0.057944	13,924,987	0	0	806,869	57.00	
58.00	05800	MRI	0.081910	24,148,363	0	0	1,977,992	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.163703	9,512,498	0	0	1,557,224	59.00	
60.00	06000	LABORATORY	0.110046	22,320,967	0	0	2,456,333	60.00	
65.00	06500	RESPIRATORY THERAPY	0.143827	1,244,609	0	0	179,008	65.00	
66.00	06600	PHYSICAL THERAPY	0.483914	241,840	0	0	117,030	66.00	
68.00	06800	SPEECH PATHOLOGY	0.694416	295,198	0	0	204,990	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.049999	11,071,750	0	0	553,576	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.525082	977,699	0	0	513,372	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.128347	13,636,602	0	0	1,750,217	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.247856	6,964,077	0	0	1,726,088	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.236066	103,532,800	25,205	0	24,440,574	73.00	
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00	
76.97	07697	CARDIAC REHABILITATION	0.989059	1,199,528	0	0	1,186,404	76.97	
	OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OP PEDS ONC CLINIC	0.429639	6,831,961	0	0	2,935,277	90.01	
90.02	09002	WOUND CLINIC	0.337415	4,980,193	0	0	1,680,392	90.02	
91.00	09100	EMERGENCY	0.130825	23,404,131	0	0	3,061,845	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.621955	4,502,856	0	0	2,800,574	92.00	
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.385462	573,137	0	0	220,923	92.01	
200.00		Subtotal (see instructions)		357,438,529	25,205	0	66,136,338	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		357,438,529	25,205	0	66,136,338	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019Worksheet D
Part V
Date/Time Prepared:
1/29/2020 12:25 pm

			Title XVIII		Hospital	PPS
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,950	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OP PEDS ONC CLINIC	0	0		90.01
90.02	09002	WOUND CLINIC	0	0		90.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
200.00		Subtotal (see instructions)	5,950	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,950	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0130	Period: From 09/01/2018 To 08/31/2019	Worksheet D-1 Date/Time Prepared: 1/29/2020 12:25 pm
		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)		30,952	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		30,952	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)		25,494	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)		10,796	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)		55,890,878	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)		55,890,878	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)		55,890,878	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)		1,805.73	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		19,494,661	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)		19,494,661	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019

Worksheet D-1

Date/Time Prepared:
1/29/2020 12:25 pm

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
	Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT	10,578,941	3,622	2,920.75	2,070	6,045,953
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)					28,958,539
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					54,499,153
	PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					3,304,989
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					3,477,433
52.00	Total Program excludable cost (sum of lines 50 and 51)					6,782,422
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					47,716,731
	TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
	PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)					5,458
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,805.73
89.00	Observation bed cost (line 87 x line 88) (see instructions)					9,855,674

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019

Worksheet D-1

Date/Time Prepared:
1/29/2020 12:25 pm

		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	7,354,075	55,890,878	0.131579	9,855,674	1,296,800	90.00
91.00 Nursing School cost	0	55,890,878	0.000000	9,855,674	0	91.00
92.00 Allied health cost	0	55,890,878	0.000000	9,855,674	0	92.00
93.00 All other Medical Education	0	55,890,878	0.000000	9,855,674	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0130	Period: From 09/01/2018 To 08/31/2019	Worksheet D-1 Date/Time Prepared: 1/29/2020 12:25 pm
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			30,952 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			30,952 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)			25,494 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)			696 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)			4,497 15.00
16.00	Nursery days (title V or XIX only)			379 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)			55,890,878 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)			55,890,878 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)			55,890,878 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)			1,805.73 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,256,788 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)			1,256,788 41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0130	Period: From 09/01/2018 To 08/31/2019	Worksheet D-1 Date/Time Prepared: 1/29/2020 12:25 pm	
			Title XIX	Hospital	Cost	
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)	4,316,023	4,497	959.76	379	363,749	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	10,578,941	3,622	2,920.75	143	417,667	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,038,204	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					5,458	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,805.73	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					9,855,674	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019

Worksheet D-1

Date/Time Prepared:
1/29/2020 12:25 pm

Cost Center Description		Title XIX		Hospital		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	7,354,075	55,890,878	0.131579	9,855,674	1,296,800	90.00
91.00	Nursing School cost	0	55,890,878	0.000000	9,855,674	0	91.00
92.00	Allied health cost	0	55,890,878	0.000000	9,855,674	0	92.00
93.00	All other Medical Education	0	55,890,878	0.000000	9,855,674	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0130	Period: From 09/01/2018 To 08/31/2019	Worksheet D-3 Date/Time Prepared: 1/29/2020 12:25 pm	
			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		29,908,832		30.00
31.00	03100	INTENSIVE CARE UNIT		21,404,111		31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.186061	34,277,050	6,377,622	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.321543	6,811	2,190	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.170171	7,326,625	1,246,779	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.120416	402,120	48,422	55.00
57.00	05700	CT SCAN	0.057944	10,919,068	632,694	57.00
58.00	05800	MRI	0.081910	4,574,639	374,709	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.163703	10,408,755	1,703,944	59.00
60.00	06000	LABORATORY	0.110046	27,918,969	3,072,371	60.00
65.00	06500	RESPIRATORY THERAPY	0.143827	10,555,326	1,518,141	65.00
66.00	06600	PHYSICAL THERAPY	0.483914	2,199	1,064	66.00
68.00	06800	SPEECH PATHOLOGY	0.694416	821,940	570,768	68.00
69.00	06900	ELECTROCARDIOLOGY	0.049999	7,479,686	373,977	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.525082	171,972	90,299	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.128347	13,721,596	1,761,126	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.247856	20,912,853	5,183,376	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.236066	12,058,137	2,846,516	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.989059	3,587	3,548	76.97
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	0.429639	94,282	40,507	90.01
90.02	09002	WOUND CLINIC	0.337415	24,572	8,291	90.02
91.00	09100	EMERGENCY	0.130825	13,153,079	1,720,752	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.621955	2,048,574	1,274,121	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.385462	278,425	107,322	92.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		177,160,265	28,958,539	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)		177,160,265		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019Worksheet E
Part A
Date/Time Prepared:
1/29/2020 12:25 pm

		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)			2,608,389	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			28,692,282	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)			0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)			0	1.04
2.00	Outlier payments for discharges. (see instructions)			1,136,451	2.00
2.01	Outlier reconciliation amount			0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)			0	2.02
3.00	Managed Care Simulated Payments			4,629,692	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			106.35	4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)			0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)			0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)			0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00	11.00
12.00	Current year allowable FTE (see instructions)			0.00	12.00
13.00	Total allowable FTE count for the prior year.			0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.			0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.00	15.00
16.00	Adjustment for residents in initial years of the program			24.40	16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00	17.00
18.00	Adjusted rolling average FTE count			24.40	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.229431	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.225508	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.225508	21.00
22.00	IME payment adjustment (see instructions)			3,627,497	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			536,544	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).			0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)			0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)			0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)			0	28.01
29.00	Total IME payment (sum of lines 22 and 28)			3,627,497	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			536,544	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			0.87	30.00
31.00	Percentage of Medicaid patient days (see instructions)			15.37	31.00
32.00	Sum of lines 30 and 31			16.24	32.00
33.00	Allowable disproportionate share percentage (see instructions)			3.31	33.00
34.00	Disproportionate share adjustment (see instructions)			259,014	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0130	Period: From 09/01/2018 To 08/31/2019	Worksheet E Part A Date/Time Prepared: 1/29/2020 12:25 pm
		Title XVIII	Hospital	PPS
			Prior to 10/1	On/After 10/1
			1.00	2.00
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	6,766,695,164	8,272,872,447	35.00
35.01	Factor 3 (see instructions)	0.000166160	0.000182009	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,124,354	1,506,316	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	92,413	1,382,509	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,474,922		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	37,798,555		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		38,335,099	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,941,815	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		544,823	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		1,750	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		41,823,487	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		41,823,487	61.00
62.00	Deductibles billed to program beneficiaries		62,222	62.00
63.00	Coinsurance billed to program beneficiaries		3,352,320	63.00
64.00	Allowable bad debts (see instructions)		216,878	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		140,971	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		176,768	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		38,549,916	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		153,320	70.93
70.94	HRR adjustment amount (see instructions)		-939,072	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019Worksheet E
Part A
Date/Time Prepared:
1/29/2020 12:25 pm

		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			404,929	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			37,359,235	71.00
71.01	Sequestration adjustment (see instructions)			747,185	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
72.00	Interim payments			34,607,416	72.00
73.00	Tentative settlement (for contractor use only)			0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)			2,004,634	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			2,186,106	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000		103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
1/29/2020 12:25 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,608,389	0	2,608,389		2,608,389
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	28,692,282	0		28,692,282	28,692,282
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00	1,136,451	0	94,704	1,041,747	1,136,451
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	4,629,692	0	385,807	4,243,884	4,629,691
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.225508	0.225508	0.225508	0.225508	
6.00	IME payment adjustment (see instructions)	22.00	3,627,497	0	302,291	3,325,206	3,627,497
6.01	IME payment adjustment for managed care (see instructions)	22.01	536,544	0	0	536,544	536,544
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	3,627,497	0	302,291	3,325,206	3,627,497
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	536,544	0	0	536,544	536,544
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0331	0.0331	0.0331	0.0331	
11.00	Disproportionate share adjustment (see instructions)	34.00	259,014	0	21,585	237,429	259,014
11.01	Uncompensated care payments	36.00	1,474,922	0	28,296	1,031,941	1,060,237
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	37,798,555	0	3,055,265	34,743,290	37,798,555
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	38,335,099	0	3,055,265	35,279,834	38,335,099
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,941,815	0	245,151	2,696,664	2,941,815
17.00	Special add-on payments for new technologies	54.00	1,750	0	0	1,750	1,750
17.01	Net organ aquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
1/29/2020 12:25 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	3,300,416	37,978,248	41,278,664
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	2,546,655	0	212,221	2,334,434	2,546,655
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	94,910	0	7,909	87,001	94,910
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0845	0.0845	0.0845	0.0845	
23.00	Indirect medical education adjustment (see instructions)	6.00	215,192	0	17,933	197,259	215,192
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0334	0.0334	0.0334	0.0334	
25.00	Disproportionate share adjustment (see instructions)	11.00	85,058	0	7,088	77,970	85,058
26.00	Total prospective capital payments (see instructions)	12.00	2,941,815	0	245,151	2,696,664	2,941,815
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.000000	0.000000	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
1/29/2020 12:25 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,608,389	2,608,389		2,608,389	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	28,692,282		28,692,282	28,692,282	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	1,136,451	94,704	1,041,747	1,136,451	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	4,629,692	385,807	4,243,885	4,629,692	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.225508	0.225508	0.225508		5.00
6.00	IME payment adjustment (see instructions)	22.00	3,627,497	302,291	3,325,206	3,627,497	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	536,544	44,712	491,832	536,544	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	3,627,497	302,291	3,325,206	3,627,497	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	536,544	44,712	491,832	536,544	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0331	0.0331	0.0331		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	259,014	21,585	237,429	259,014	11.00
11.01	Uncompensated care payments	36.00	1,474,922	92,413	1,382,509	1,474,922	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	37,798,555	3,119,382	34,679,173	37,798,555	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	38,335,099	3,164,094	35,171,005	38,335,099	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,941,815	245,151	2,696,664	2,941,815	16.00
17.00	Special add-on payments for new technologies	54.00	1,750	0	1,750	1,750	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			3,409,245	37,869,419	41,278,664	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
1/29/2020 12:25 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	2,546,655	212,221	2,334,434	2,546,655	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	94,910	7,909	87,001	94,910	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0845	0.0845	0.0845		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	215,192	17,933	197,259	215,192	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0334	0.0334	0.0334		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	85,058	7,088	77,970	85,058	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,941,815	245,151	2,696,664	2,941,815	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	153,320	12,777	140,543	153,320	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-939,072	-78,256	-860,816	-939,072	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		33,438	371,491	404,929	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0130	Period: From 09/01/2018 To 08/31/2019	Worksheet E Part B Date/Time Prepared: 1/29/2020 12:25 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,950	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		66,136,338	2.00
3.00	OPPS payments		43,759,088	3.00
4.00	Outlier payment (see instructions)		660,854	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		5,950	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		25,205	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)		25,205	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)		25,205	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		19,255	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)		5,950	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)		44,419,942	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		8,115,778	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)		36,310,114	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		661,146	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)		36,971,260	30.00
31.00	Primary payer payments		7,119	31.00
32.00	Subtotal (line 30 minus line 31)		36,964,141	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)		475,631	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		309,160	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		369,193	36.00
37.00	Subtotal (see instructions)		37,273,301	37.00
38.00	MSP-LCC reconciliation amount from PS&R		75	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		37,273,226	40.00
40.01	Sequestration adjustment (see instructions)		745,465	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		36,511,888	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		15,873	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019Worksheet E-1
Part I
Date/Time Prepared:
1/29/2020 12:25 pm

		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		33,706,775		35,570,808	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		555,375		628,769	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	03/06/2019	152,932	03/06/2019	10,514	3.01
3.02		07/25/2019	192,334	07/25/2019	301,797	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
3.06			0		0	3.06
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)		345,266		312,311	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)		34,607,416		36,511,888	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		2,004,634		15,873	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		36,612,050		36,527,761	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: 14-0130

Period:
From 09/01/2018
To 08/31/2019Worksheet E-1
Part II
Date/Time Prepared:
1/29/2020 12:25 pm

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: 14-0130	Period: From 09/01/2018 To 08/31/2019	Worksheet E-3 Part VII Date/Time Prepared: 1/29/2020 12:25 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services	2,038,204			1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)	0			3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	2,038,204		0	4.00
5.00	Inpatient primary payer payments	0			5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	2,038,204		0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges	0			8.00
9.00	Ancillary service charges	0		0	9.00
10.00	Organ acquisition charges, net of revenue	0			10.00
11.00	Incentive from target amount computation	0			11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0		0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0		0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0		0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000		0.000000	15.00
16.00	Total customary charges (see instructions)	0		0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0		0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	2,038,204		0	18.00
19.00	Interns and Residents (see instructions)	0		0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0		0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments	0		0	22.00
23.00	Outlier payments	0		0	23.00
24.00	Program capital payments	0			24.00
25.00	Capital exception payments (see instructions)	0			25.00
26.00	Routine and Ancillary service other pass through costs	0		0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0			28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0		0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)	2,038,204		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0		0	31.00
32.00	Deductibles	0		0	32.00
33.00	Coinurance	0		0	33.00
34.00	Allowable bad debts (see instructions)	0		0	34.00
35.00	Utilization review	0			35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0		0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		0	37.00
38.00	Subtotal (line 36 ± line 37)	0		0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0			39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0		0	40.00
41.00	Interim payments	0		0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0		0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0		0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0130	Period: From 09/01/2018 To 08/31/2019	Worksheet E-4 Date/Time Prepared: 1/29/2020 12:25 pm	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.00	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.00	0.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	24.40	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	24.40	0.00		17.00
18.00	Per resident amount	104,797.70	0.00		18.00
19.00	Approved amount for resident costs	2,557,064	0	2,557,064	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			2,557,064	25.00
		Inpatient Part	Managed care		
		A			
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	12,866	2,043		26.00
27.00	Total Inpatient Days (see instructions)	31,000	31,000		27.00
28.00	Ratio of inpatient days to total inpatient days	0.415032	0.065903		28.00
29.00	Program direct GME amount	1,061,263	168,518		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		23,812		30.00
31.00	Net Program direct GME amount			1,205,969	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0130	Period: From 09/01/2018 To 08/31/2019	Worksheet E-4 Date/Time Prepared: 1/29/2020 12:25 pm	
		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)			54,499,153	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)			0	39.00
40.00	Primary payer payments (see instructions)			0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			54,499,153	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			66,142,288	42.00
43.00	Primary payer payments (see instructions)			7,119	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			66,135,169	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			120,634,322	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.451772	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.548228	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			1,205,969	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			544,823	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			661,146	50.00

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

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019

Worksheet G

Date/Time Prepared:
1/29/2020 12:25 pm

	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	0	31,124,810	30,647,526	0	1.00
2.00 Temporary investments	0	0	0	0	2.00
3.00 Notes receivable	6,075,356	0	0	0	3.00
4.00 Accounts receivable	72,410,468	0	0	0	4.00
5.00 Other receivable	2,048,051	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-27,735,698	0	0	0	6.00
7.00 Inventory	6,772,699	0	0	0	7.00
8.00 Prepaid expenses	760,561	0	0	0	8.00
9.00 Other current assets	6,202,246	0	0	0	9.00
10.00 Due from other funds	-3,787,787	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	62,745,896	31,124,810	30,647,526	0	11.00
FIXED ASSETS					
12.00 Land	52,023,598	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	534,605,793	0	0	0	15.00
16.00 Accumulated depreciation	-93,787,393	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	113,949,670	0	0	0	19.00
20.00 Accumulated depreciation	-51,711,744	0	0	0	20.00
21.00 Automobiles and trucks	0	0	0	0	21.00
22.00 Accumulated depreciation	0	0	0	0	22.00
23.00 Major movable equipment	0	0	0	0	23.00
24.00 Accumulated depreciation	0	0	0	0	24.00
25.00 Minor equipment depreciable	0	0	0	0	25.00
26.00 Accumulated depreciation	0	0	0	0	26.00
27.00 HIT designated Assets	0	0	0	0	27.00
28.00 Accumulated depreciation	0	0	0	0	28.00
29.00 Minor equipment-nondepreciable	0	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	555,079,924	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	77,873,267	-2,737,921	1,166,660	0	31.00
32.00 Deposits on leases	0	0	0	0	32.00
33.00 Due from owners/officers	4	0	0	0	33.00
34.00 Other assets	0	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	77,873,271	-2,737,921	1,166,660	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	695,699,091	28,386,889	31,814,186	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	6,918,054	0	0	0	37.00
38.00 Salaries, wages, and fees payable	11,616,955	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	0	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	59,391,017	0	0	0	43.00
44.00 Other current liabilities	9,176,050	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	87,102,076	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	0	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	51,273,609	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	51,273,609	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	138,375,685	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	557,323,406				52.00
53.00 Specific purpose fund		28,386,889			53.00
54.00 Donor created - endowment fund balance - restricted			31,814,186		54.00
55.00 Donor created - endowment fund balance - unrestricted			0		55.00
56.00 Governing body created - endowment fund balance			0		56.00
57.00 Plant fund balance - invested in plant				0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	557,323,406	28,386,889	31,814,186	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	695,699,091	28,386,889	31,814,186	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019

Worksheet G-1

Date/Time Prepared:
1/29/2020 12:25 pm

		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		579,904,578		31,124,810		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-7,439,042				2.00
3.00	Total (sum of line 1 and line 2)		572,465,536		31,124,810		3.00
4.00	ASSET RELEA TO FINANCE PROP AND EQUI	8,301,024		0		0	4.00
5.00	OTHER	842		0		0	5.00
6.00	POST BENE TO RELATED TO NET PENSION	0		0		0	6.00
7.00	GIFTS AND OTHER REVENUE	0		5,423,157		216,660	7.00
8.00	INTERCOMPANY SETTLEMENTS	18,833,085		321,768		950,000	8.00
9.00	INVESTMENT INCOM & CHG IN NET ASSETS	0		3,302,862		0	9.00
10.00	Total additions (sum of line 4-9)		27,134,951		9,047,787		10.00
11.00	Subtotal (line 3 plus line 10)		599,600,487		40,172,597		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	OPERATING EXPENSES	0		2,498,683		0	13.00
14.00	PROPERTY ADDITIONS	0		8,301,024		0	14.00
15.00	RECLASSIFICATION	42,277,081		950,000		0	15.00
16.00	OTHER	0		36,001		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		42,277,081		11,785,708		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		557,323,406		28,386,889		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	30,647,526		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)	30,647,526		0			3.00
4.00	ASSET RELEA TO FINANCE PROP AND EQUI		0				4.00
5.00	OTHER		0				5.00
6.00	POST BENE TO RELATED TO NET PENSION		0				6.00
7.00	GIFTS AND OTHER REVENUE		0				7.00
8.00	INTERCOMPANY SETTLEMENTS		0				8.00
9.00	INVESTMENT INCOM & CHG IN NET ASSETS		0				9.00
10.00	Total additions (sum of line 4-9)	1,166,660		0			10.00
11.00	Subtotal (line 3 plus line 10)	31,814,186		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00	OPERATING EXPENSES		0				13.00
14.00	PROPERTY ADDITIONS		0				14.00
15.00	RECLASSIFICATION		0				15.00
16.00	OTHER		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)	31,814,186		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
1/29/2020 12:25 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	91,816,417		91,816,417	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	91,816,417		91,816,417	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	18,168,127		18,168,127	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)	18,168,127		18,168,127	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	109,984,544		109,984,544	17.00
18.00	Ancillary services	431,166,469	0	431,166,469	18.00
19.00	Outpatient services	0	1,303,649,594	1,303,649,594	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		3,676,166	3,676,166	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	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)	541,151,013	1,307,325,760	1,848,476,773	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		393,931,577		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	BAD DEBT	0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		393,931,577		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0130

Period:
From 09/01/2018
To 08/31/2019

Worksheet G-3

Date/Time Prepared:
1/29/2020 12:25 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,848,476,773	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,491,002,854	2.00
3.00	Net patient revenues (line 1 minus line 2)	357,473,919	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	393,931,577	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-36,457,658	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	3,431,274	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	1,342,342	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	18,024	21.00
22.00	Rental of hospital space	7,543,830	22.00
23.00	Governmental appropriations	38,150	23.00
24.00	NET ASSETS AND HAP REVENUE	13,828,970	24.00
24.01	OTHER INCOME	2,816,026	24.01
25.00	Total other income (sum of lines 6-24)	29,018,616	25.00
26.00	Total (line 5 plus line 25)	-7,439,042	26.00
27.00	OTHER	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)	-7,439,042	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0130

Period:

Worksheet H

HHA CCN: 14-7045

From 09/01/2018

Date/Time Prepared:

To 08/31/2019

1/29/2020 12:25 pm

Home Health
Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00 Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00 Capital Related - Movable Equipment			0		0	0	2.00
3.00 Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00 Transportation	0	0	0	0	0	0	4.00
5.00 Administrative and General	452,402	0	0	0	122,527	574,929	5.00
HHA REIMBURSABLE SERVICES							
6.00 Skilled Nursing Care	1,245,488	0	0	0	337,323	1,582,811	6.00
7.00 Physical Therapy	446,985	0	0	0	121,060	568,045	7.00
8.00 Occupational Therapy	125,065	0	0	0	33,872	158,937	8.00
9.00 Speech Pathology	0	0	0	0	0	0	9.00
10.00 Medical Social Services	35,693	0	0	0	9,667	45,360	10.00
11.00 Home Health Aide	49,203	0	0	0	13,326	62,529	11.00
12.00 Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00 Drugs	0	0	0	0	0	0	13.00
14.00 DME	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00 Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00 Respiratory Therapy	0	0	0	0	0	0	16.00
17.00 Private Duty Nursing	0	0	0	0	0	0	17.00
18.00 Clinic	0	0	0	0	0	0	18.00
19.00 Health Promotion Activities	0	0	0	0	0	0	19.00
20.00 Day Care Program	0	0	0	0	0	0	20.00
21.00 Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00 Homemaker Service	0	0	0	0	0	0	22.00
23.00 All Others (specify)	0	0	0	0	0	0	23.00
23.50 Telemedicine	0	0	0	0	0	0	23.50
24.00 Total (sum of lines 1-23)	2,354,836	0	0	0	637,775	2,992,611	24.00
	Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00 Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00 Capital Related - Movable Equipment	0	0	0	0			2.00
3.00 Plant Operation & Maintenance	0	0	0	0			3.00
4.00 Transportation	0	0	0	0			4.00
5.00 Administrative and General	0	574,929	-264,055	310,874			5.00
HHA REIMBURSABLE SERVICES							
6.00 Skilled Nursing Care	0	1,582,811	-726,959	855,852			6.00
7.00 Physical Therapy	0	568,045	-260,893	307,152			7.00
8.00 Occupational Therapy	0	158,937	-72,997	85,940			8.00
9.00 Speech Pathology	0	0	0	0			9.00
10.00 Medical Social Services	0	45,360	-20,833	24,527			10.00
11.00 Home Health Aide	0	62,529	-28,719	33,810			11.00
12.00 Supplies (see instructions)	0	0	0	0			12.00
13.00 Drugs	0	0	0	0			13.00
14.00 DME	0	0	0	0			14.00
HHA NONREIMBURSABLE SERVICES							
15.00 Home Dialysis Aide Services	0	0	0	0			15.00
16.00 Respiratory Therapy	0	0	0	0			16.00
17.00 Private Duty Nursing	0	0	0	0			17.00
18.00 Clinic	0	0	0	0			18.00
19.00 Health Promotion Activities	0	0	0	0			19.00
20.00 Day Care Program	0	0	0	0			20.00
21.00 Home Delivered Meals Program	0	0	0	0			21.00
22.00 Homemaker Service	0	0	0	0			22.00
23.00 All Others (specify)	0	0	0	0			23.00
23.50 Telemedicine	0	0	0	0			23.50
24.00 Total (sum of lines 1-23)	0	2,992,611	-1,374,456	1,618,155			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-0130

Period:

Worksheet H-1

HHA CCN: 14-7045

From 09/01/2018
To 08/31/2019Part I
Date/Time Prepared:
1/29/2020 12:25 pmHome Health
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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)		
			Bldgs & Fixtures	Movable Equipment					
		0	1.00	2.00	3.00	4.00	4A.00		
	GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00	
2.00	Capital Related - Movable Equipment	0		0			0	2.00	
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00	
4.00	Transportation	0	0	0	0	0		4.00	
5.00	Administrative and General	310,874	0	0	0	0	310,874	5.00	
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	855,852	0	0	0	0	855,852	6.00	
7.00	Physical Therapy	307,152	0	0	0	0	307,152	7.00	
8.00	Occupational Therapy	85,940	0	0	0	0	85,940	8.00	
9.00	Speech Pathology	0	0	0	0	0	0	9.00	
10.00	Medical Social Services	24,527	0	0	0	0	24,527	10.00	
11.00	Home Health Aide	33,810	0	0	0	0	33,810	11.00	
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00	
13.00	Drugs	0	0	0	0	0	0	13.00	
14.00	DME	0	0	0	0	0	0	14.00	
	HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	0	23.00	
23.50	Telemedicine	0	0	0	0	0	0	23.50	
24.00	Total (sum of lines 1-23)	1,618,155	0	0	0	0	1,618,155	24.00	
		Administrative & General	Total (cols. 4A + 5)						
		5.00	6.00						
	GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures								1.00
2.00	Capital Related - Movable Equipment								2.00
3.00	Plant Operation & Maintenance								3.00
4.00	Transportation								4.00
5.00	Administrative and General	310,874							5.00
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	193,618	1,049,470						6.00
7.00	Physical Therapy	83,952	391,104						7.00
8.00	Occupational Therapy	17,486	103,426						8.00
9.00	Speech Pathology	0	0						9.00
10.00	Medical Social Services	5,836	30,363						10.00
11.00	Home Health Aide	9,982	43,792						11.00
12.00	Supplies (see instructions)	0	0						12.00
13.00	Drugs	0	0						13.00
14.00	DME	0	0						14.00
	HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0						15.00
16.00	Respiratory Therapy	0	0						16.00
17.00	Private Duty Nursing	0	0						17.00
18.00	Clinic	0	0						18.00
19.00	Health Promotion Activities	0	0						19.00
20.00	Day Care Program	0	0						20.00
21.00	Home Delivered Meals Program	0	0						21.00
22.00	Homemaker Service	0	0						22.00
23.00	All Others (specify)	0	0						23.00
23.50	Telemedicine	0	0						23.50
24.00	Total (sum of lines 1-23)		1,618,155						24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-0130

Period:

Worksheet H-1

HHA CCN: 14-7045

From 09/01/2018
To 08/31/2019Part II
Date/Time Prepared:
1/29/2020 12:25 pmHome Health
Agency I

PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00	3.00	4.00	5A.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-310,874	5.00
						1,512,844	
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	86,376	6.00
7.00	Physical Therapy	0	0	0	0	101,394	7.00
8.00	Occupational Therapy	0	0	0	0	-847	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	3,874	10.00
11.00	Home Health Aide	0	0	0	0	14,766	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-105,311	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0	310,874	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000	0.205490	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0130

Period:

Worksheet H-2

HHA CCN: 14-7045

From 09/01/2018
To 08/31/2019Part I
Date/Time Prepared:
1/29/2020 12:25 pmHome Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			BLDG & FIXT	MVBLE EQUIP				
			0	1.00			2.00	
1.00	Administrative and General	0	0	3,139	5,584	8,723	1,582	1.00
2.00	Skilled Nursing Care	1,049,470	0	0	15,371	1,064,841	488,651	2.00
3.00	Physical Therapy	391,104	0	0	5,517	396,621	211,279	3.00
4.00	Occupational Therapy	103,426	0	0	1,544	104,970	44,006	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	30,363	0	0	441	30,804	14,687	6.00
7.00	Home Health Aide	43,792	0	0	607	44,399	25,121	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,618,155	0	3,139	29,064	1,650,358	785,326	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00
Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	
		7.00	8.00	9.00	10.00	11.00	12.00	
1.00	Administrative and General	2,136	0	0	0	27,491	0	1.00
2.00	Skilled Nursing Care	5,740	0	0	0	75,682	0	2.00
3.00	Physical Therapy	2,403	0	0	0	27,160	0	3.00
4.00	Occupational Therapy	534	0	0	0	7,599	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	134	0	0	0	2,169	0	6.00
7.00	Home Health Aide	267	0	0	0	2,990	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	11,214	0	0	0	143,091	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0130

Period:

Worksheet H-2

HHA CCN: 14-7045

From 09/01/2018
To 08/31/2019Part I
Date/Time Prepared:
1/29/2020 12:25 pmHome Health
Agency I

PPS

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV	
		13.00	14.00	15.00	16.00	17.00	21.00	
1.00	Administrative and General	92,561	1,435	0	775	0	0	1.00
2.00	Skilled Nursing Care	254,822	3,953	0	2,136	0	0	2.00
3.00	Physical Therapy	91,445	1,418	0	766	0	0	3.00
4.00	Occupational Therapy	25,582	397	0	214	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	7,324	113	0	61	0	0	6.00
7.00	Home Health Aide	10,062	156	0	84	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	481,796	7,472	0	4,036	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		SERVICES-OTHER PRGM COSTS APPRV	EMS PARAMEDICAL PROGRAM					
		22.00	22.01	24.00	25.00	26.00	27.00	
1.00	Administrative and General	0	0	134,703	0	134,703		1.00
2.00	Skilled Nursing Care	0	0	1,895,825	0	1,895,825	86,609	2.00
3.00	Physical Therapy	0	0	731,092	0	731,092	33,399	3.00
4.00	Occupational Therapy	0	0	183,302	0	183,302	8,374	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	55,292	0	55,292	2,526	6.00
7.00	Home Health Aide	0	0	83,079	0	83,079	3,795	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	3,083,293	0	3,083,293	134,703	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						0.045684	21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0130

Period:

Worksheet H-2

HHA CCN: 14-7045

From 09/01/2018
To 08/31/2019Part I
Date/Time Prepared:
1/29/2020 12:25 pmHome Health
Agency I

PPS

Cost Center Description		Total HHA Costs		
		28.00		
1.00	Administrative and General			1.00
2.00	Skilled Nursing Care	1,982,434		2.00
3.00	Physical Therapy	764,491		3.00
4.00	Occupational Therapy	191,676		4.00
5.00	Speech Pathology	0		5.00
6.00	Medical Social Services	57,818		6.00
7.00	Home Health Aide	86,874		7.00
8.00	Supplies (see instructions)	0		8.00
9.00	Drugs	0		9.00
10.00	DME	0		10.00
11.00	Home Dialysis Aide Services	0		11.00
12.00	Respiratory Therapy	0		12.00
13.00	Private Duty Nursing	0		13.00
14.00	Clinic	0		14.00
15.00	Health Promotion Activities	0		15.00
16.00	Day Care Program	0		16.00
17.00	Home Delivered Meals Program	0		17.00
18.00	Homemaker Service	0		18.00
19.00	All Others (specify)	0		19.00
19.50	Telemedicine	0		19.50
20.00	Total (sum of lines 1-19) (2)	3,083,293		20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0130

Period:

Worksheet H-2

HHA CCN: 14-7045

From 09/01/2018

Part II

To 08/31/2019

Date/Time Prepared:

1/29/2020 12:25 pm

Home Health
Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS			Reconciliation	Agency 1	OPERATION OF PLANT (SQUARE FEET)	
		BLDG & FIXT (DV SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)		ADMINISTRATIVE & GENERAL (ACCUM COST)		
						1.00		
1.00	Administrative and General	0	3,178	441,401	-4,952	3,771	16	1.00
2.00	Skilled Nursing Care	0	0	1,215,202	99,688	1,164,529	43	2.00
3.00	Physical Therapy	0	0	436,116	106,888	503,509	18	3.00
4.00	Occupational Therapy	0	0	122,024	-98	104,872	4	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	34,825	4,197	35,001	1	6.00
7.00	Home Health Aide	0	0	48,007	15,468	59,867	2	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	3,178	2,297,575		1,871,549	84	20.00
21.00	Total cost to be allocated	0	3,139	29,064		785,326	11,214	21.00
22.00	Unit cost multiplier	0.000000	0.987728	0.012650		0.419613	133.500000	22.00
Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	
		8.00	9.00	10.00	11.00	12.00	13.00	
1.00	Administrative and General	0	0	0	10,556	0	5,308	1.00
2.00	Skilled Nursing Care	0	0	0	29,061	0	14,613	2.00
3.00	Physical Therapy	0	0	0	10,429	0	5,244	3.00
4.00	Occupational Therapy	0	0	0	2,918	0	1,467	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	833	0	420	6.00
7.00	Home Health Aide	0	0	0	1,148	0	577	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	54,945	0	27,629	20.00
21.00	Total cost to be allocated	0	0	0	143,091	0	481,796	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	2.604259	0.000000	17.438054	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0130

Period:

Worksheet H-2

HHA CCN: 14-7045

From 09/01/2018
To 08/31/2019Part II
Date/Time Prepared:
1/29/2020 12:25 pm

						Home Health Agency I	PPS		
Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	INTERNS & RESIDENTS			
						SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
						14.00	15.00	16.00	17.00
1.00	Administrative and General	6,673	0	706,251	0	0	0	1.00	
2.00	Skilled Nursing Care	18,372	0	1,944,348	0	0	0	2.00	
3.00	Physical Therapy	6,593	0	697,794	0	0	0	3.00	
4.00	Occupational Therapy	1,845	0	195,241	0	0	0	4.00	
5.00	Speech Pathology	0	0	0	0	0	0	5.00	
6.00	Medical Social Services	526	0	55,721	0	0	0	6.00	
7.00	Home Health Aide	726	0	76,811	0	0	0	7.00	
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00	
9.00	Drugs	0	0	0	0	0	0	9.00	
10.00	DME	0	0	0	0	0	0	10.00	
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00	Clinic	0	0	0	0	0	0	14.00	
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00	Day Care Program	0	0	0	0	0	0	16.00	
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00	Homemaker Service	0	0	0	0	0	0	18.00	
19.00	All Others (specify)	0	0	0	0	0	0	19.00	
19.50	Telemedicine	0	0	0	0	0	0	19.50	
20.00	Total (sum of lines 1-19)	34,735	0	3,676,166	0	0	0	20.00	
21.00	Total cost to be allocated	7,472	0	4,036	0	0	0	21.00	
22.00	Unit cost multiplier	0.215114	0.000000	0.001098	0.000000	0.000000	0.000000	22.00	
Cost Center Description		INTERNS & RESIDENTS							
		EMS							
		PARAMEDICAL PROGRAM (ASSIGNED TIME)							
		22.01							
1.00	Administrative and General	0							1.00
2.00	Skilled Nursing Care	0							2.00
3.00	Physical Therapy	0							3.00
4.00	Occupational Therapy	0							4.00
5.00	Speech Pathology	0							5.00
6.00	Medical Social Services	0							6.00
7.00	Home Health Aide	0							7.00
8.00	Supplies (see instructions)	0							8.00
9.00	Drugs	0							9.00
10.00	DME	0							10.00
11.00	Home Dialysis Aide Services	0							11.00
12.00	Respiratory Therapy	0							12.00
13.00	Private Duty Nursing	0							13.00
14.00	Clinic	0							14.00
15.00	Health Promotion Activities	0							15.00
16.00	Day Care Program	0							16.00
17.00	Home Delivered Meals Program	0							17.00
18.00	Homemaker Service	0							18.00
19.00	All Others (specify)	0							19.00
19.50	Telemedicine	0							19.50
20.00	Total (sum of lines 1-19)	0							20.00
21.00	Total cost to be allocated	0							21.00
22.00	Unit cost multiplier	0.000000							22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0130

Period:

Worksheet H-3

HHA CCN: 14-7045

From 09/01/2018
To 08/31/2019Part I
Date/Time Prepared:
1/29/2020 12:25 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	1,982,434		1,982,434	5,477	361.96	1.00
2.00	Physical Therapy	3.00	764,491	0	764,491	3,071	248.94	2.00
3.00	Occupational Therapy	4.00	191,676	0	191,676	883	217.07	3.00
4.00	Speech Pathology	5.00	0	0	0	1	0.00	4.00
5.00	Medical Social Services	6.00	57,818		57,818	221	261.62	5.00
6.00	Home Health Aide	7.00	86,874		86,874	415	209.33	6.00
7.00	Total (sum of lines 1-6)		3,083,293	0	3,083,293	10,068		7.00
				Program Visits				
				Part B				
				Not Subject to Deductibles & Coinsurance		Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care		16974	0	811			8.00
8.01	Skilled Nursing Care		29404	0	4,666			8.01
9.00	Physical Therapy		16974	0	540			9.00
9.01	Physical Therapy		29404	0	2,531			9.01
10.00	Occupational Therapy		16974	0	123			10.00
10.01	Occupational Therapy		29404	0	760			10.01
11.00	Speech Pathology		16974	0	1			11.00
11.01	Speech Pathology		29404	0	0			11.01
12.00	Medical Social Services		16974	0	29			12.00
12.01	Medical Social Services		29404	0	192			12.01
13.00	Home Health Aide		16974	0	87			13.00
13.01	Home Health Aide		29404	0	328			13.01
14.00	Total (sum of lines 8-13)			0	10,068			14.00
		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	0	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00
				Program Visits		Cost of Services		
				Part B		Part B		
				Not Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance		
				Subject to Deductibles & Coinsurance		Subject to Deductibles & Coinsurance		
		6.00	7.00	8.00	9.00	10.00	11.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	0	5,477		0	1,982,455		1.00
2.00	Physical Therapy	0	3,071		0	764,495		2.00
3.00	Occupational Therapy	0	883		0	191,673		3.00
4.00	Speech Pathology	0	1		0	0		4.00
5.00	Medical Social Services	0	221		0	57,818		5.00
6.00	Home Health Aide	0	415		0	86,872		6.00
7.00	Total (sum of lines 1-6)	0	10,068		0	3,083,313		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0130

Period:

Worksheet H-3

HHA CCN: 14-7045

From 09/01/2018
To 08/31/2019Part I
Date/Time Prepared:
1/29/2020 12:25 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description						Agency 1			
		6.00	7.00	8.00	9.00	10.00	11.00		
	Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00	
8.01	Skilled Nursing Care							8.01	
9.00	Physical Therapy							9.00	
9.01	Physical Therapy							9.01	
10.00	Occupational Therapy							10.00	
10.01	Occupational Therapy							10.01	
11.00	Speech Pathology							11.00	
11.01	Speech Pathology							11.01	
12.00	Medical Social Services							12.00	
12.01	Medical Social Services							12.01	
13.00	Home Health Aide							13.00	
13.01	Home Health Aide							13.01	
14.00	Total (sum of lines 8-13)							14.00	
Cost Center Description		Program Covered Charges			Cost of Services				
		Part A	Part B		Part A	Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
			6.00	7.00		8.00	9.00	10.00	11.00
	Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00	
16.00	Cost of Drugs		0	0		0	0	16.00	
Cost Center Description		Total Program Cost (sum of cols. 9-10)							
		12.00							
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	1,982,455							1.00
2.00	Physical Therapy	764,495							2.00
3.00	Occupational Therapy	191,673							3.00
4.00	Speech Pathology	0							4.00
5.00	Medical Social Services	57,818							5.00
6.00	Home Health Aide	86,872							6.00
7.00	Total (sum of lines 1-6)	3,083,313							7.00
Cost Center Description									
		12.00							
	Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00	
8.01	Skilled Nursing Care							8.01	
9.00	Physical Therapy							9.00	
9.01	Physical Therapy							9.01	
10.00	Occupational Therapy							10.00	
10.01	Occupational Therapy							10.01	
11.00	Speech Pathology							11.00	
11.01	Speech Pathology							11.01	
12.00	Medical Social Services							12.00	
12.01	Medical Social Services							12.01	
13.00	Home Health Aide							13.00	
13.01	Home Health Aide							13.01	
14.00	Total (sum of lines 8-13)							14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0130

Period:

Worksheet H-3

HHA CCN: 14-7045

From 09/01/2018
To 08/31/2019Part II
Date/Time Prepared:
1/29/2020 12:25 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.483914	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy							2.00
3.00 Speech Pathology	68.00	0.694416	0	0	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.128347	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.236066	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0130 HHA CCN: 14-7045		Period: From 09/01/2018 To 08/31/2019		Worksheet H-4 Part I-II Date/Time Prepared: 1/29/2020 12:25 pm	
		Title XVIII		Home Health Agency I		PPS	
		Part A		Part B			
				Not Subject to Deductibles & Coinsurance		Subject to Deductibles & Coinsurance	
		1.00		2.00		3.00	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES							
Reasonable Cost of Part A & Part B Services							
1.00	Reasonable cost of services (see instructions)	0	0	0	0	0	1.00
2.00	Total charges	0	0	0	0	0	2.00
Customary Charges							
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	0	0	9.00
				Part A Services		Part B Services	
				1.00		2.00	
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT							
10.00	Total reasonable cost (see instructions)	0	0	0	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	0	1,521,745	0	0	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	0	247,872	0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	0	40,934	0	0	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	0	39,181	0	0	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	0	58,320	0	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	0	0	0	16.00
17.00	Total Other Payments	0	0	0	0	0	17.00
18.00	DME Payments	0	0	0	0	0	18.00
19.00	Oxygen Payments	0	0	0	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	0	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)	0	0	0	0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	0	1,908,052	0	0	22.00
23.00	Excess reasonable cost (from line 8)	0	0	0	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	0	1,908,052	0	0	24.00
25.00	Coinsurance billed to program patients (from your records)	0	0	0	0	0	25.00
26.00	Net cost (line 24 minus line 25)	0	0	1,908,052	0	0	26.00
27.00	Reimbursable bad debts (from your records)	0	0	0	0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	0	0	0	28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	0	1,908,052	0	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	0	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	0	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	0	0	0	30.99
31.00	Subtotal (see instructions)	0	0	1,908,052	0	0	31.00
31.01	Sequestration adjustment (see instructions)	0	0	0	0	0	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	0	0	0	31.02
32.00	Interim payments (see instructions)	0	0	1,908,052	0	0	32.00
33.00	Tentative settlement (for contractor use only)	0	0	0	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	0	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	0	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED
TO PROGRAM BENEFICIARIES

Provider CCN: 14-0130

Period:

Worksheet H-5

HHA CCN: 14-7045

From 09/01/2018
To 08/31/2019Date/Time Prepared:
1/29/2020 12:25 pmHome Health
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		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		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		1,908,052	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			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			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. H-4, Part II, column as appropriate, line 32)		0		1,908,052	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			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		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		1,908,052	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0130	Period: From 09/01/2018 To 08/31/2019	Worksheet L Parts I-III Date/Time Prepared: 1/29/2020 12:25 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		2,546,655	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		94,910	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)		84.93	3.00
4.00	Number of interns & residents (see instructions)		24.40	4.00
5.00	Indirect medical education percentage (see instructions)		8.45	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)		215,192	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.87	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		15.37	8.00
9.00	Sum of lines 7 and 8		16.24	9.00
10.00	Allowable disproportionate share percentage (see instructions)		3.34	10.00
11.00	Disproportionate share adjustment (see instructions)		85,058	11.00
12.00	Total prospective capital payments (see instructions)		2,941,815	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