

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: 14-0161	Period: From 10/01/2018 To 09/30/2019	Worksheet S Parts I-III Date/Time Prepared: 2/19/2020 12:03 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 2/19/2020	Time: 12:03 pm
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SAINT JAMES HOSPITAL (14-0161) for the cost reporting period beginning 10/01/2018 and ending 09/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) _____

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-33,883	-6,955	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-33,883	-6,955	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 14-0161		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/19/2020 12:03 pm		
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 2500 WEST REYNOLDS STREET			PO Box:				1.00			
2.00	City: PONTIAC			State: IL		Zip Code: 61764		County: LIVINGSTON			
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
								V	XVIII	XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		SAINT JAMES HOSPITAL		140161	99914	1	07/01/1966	N	P	O
4.00	Subprovider - IPF										
5.00	Subprovider - IRF										
6.00	Subprovider - (Other)										
7.00	Swing Beds - SNF		ST JAMES HOSPITAL SWING		14U161	99914		10/10/2002	N	P	N
8.00	Swing Beds - NF										
9.00	Hospital-Based SNF										
10.00	Hospital-Based NF										
11.00	Hospital-Based OLTC										
12.00	Hospital-Based HHA										
13.00	Separately Certified ASC										
14.00	Hospital-Based Hospice										
15.00	Hospital-Based Health Clinic - RHC										
16.00	Hospital-Based Health Clinic - FQHC										
17.00	Hospital-Based (CMHC) I										
18.00	Renal Dialysis										
19.00	Other										
								From:	To:		
								1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)							10/01/2018	09/30/2019		
21.00	Type of Control (see instructions)							1			
								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				
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y				
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N				
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		N		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N				
				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.			196	117	0	0	665	38		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part I
Date/Time Prepared:
2/19/2020 12:03 pm

		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.					2		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.					2		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.					1		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.					10/01/2018	09/30/2019	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)					Y	Y	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	Y	40.00
						V	XVIII	XIX
						1.00	2.00	3.00
Prospective Payment System (PPS)-Capital								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	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.					N		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
				1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)					N		60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part I
Date/Time Prepared:
2/19/2020 12:03 pm

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

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To 09/30/2019Worksheet S-2
Part I
Date/Time Prepared:
2/19/2020 12:03 pm

	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	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		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	75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00

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

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			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
			1.00	2.00	3.00
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:	28,306	0	67,825	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.	Y		Y	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		149006	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0161		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/19/2020 12:03 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: OSF HEALTHCARE SYSTEM		Contractor's Name: WPS		Contractor's Number: 06101				141.00	
142.00	Street: 800 N.E. GLEN OAK AVENUE		PO Box:						142.00	
143.00	City: PEORIA		State: IL		Zip Code: 61603				143.00	
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?								Y	144.00
								1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				N				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								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)								9.99	169.00
						Beginning	Ending			
						1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					10/01/2018	09/30/2019		170.00	
						1.00	2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N	0		171.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0161	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part II Date/Time Prepared: 2/19/2020 12:03 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	01/29/2020 4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	12/13/2019	Y 12/13/2019
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part II
Date/Time Prepared:
2/19/2020 12:03 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			Y	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			Y	35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MARLIN	SILVER		41.00
42.00	Enter the employer/company name of the cost report preparer.	OSF HEALTHCARE SYSTEM			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(309) - 624 - 2870	MARLIN.L.SILVER@OSFHEALTHCAR E.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0161	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part II Date/Time Prepared: 2/19/2020 12:03 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.	GOVT REIMBURSEMENT SENIOR ANALYST		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/19/2020 12:03 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	37	13,505	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)		37	13,505	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	5	1,825	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)		42	15,330	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		42			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/19/2020 12:03 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)	2,912	87	4,923			1.00
2.00	HMO and other (see instructions)	924	781				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	86	0	132			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)	2,998	87	5,055			7.00
8.00	INTENSIVE CARE UNIT	559	26	935			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		84	408			13.00
14.00	Total (see instructions)	3,557	197	6,398	0.00	299.89	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						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	299.89	27.00
28.00	Observation Bed Days		177	1,099			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	38	54			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/19/2020 12:03 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	932	62	1,780	1.00
2.00 HMO and other (see instructions)			235	207		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	932	62	1,780	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part II
Date/Time Prepared:
2/19/2020 12:03 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	19,113,000	40,727	19,153,727	574,880.00	33.32	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		528,130	0	528,130	5,625.00	93.89	3.00
4.00	Physician-Part A - Administrative		122,120	0	122,120	713.00	171.28	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		890,549	0	890,549	4,093.00	217.58	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	0	0	0	0.00	0.00	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)		109,971	3,469	113,440	5,533.00	20.50	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,306,448	0	1,306,448	19,725.00	66.23	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		36,346	0	36,346	209.00	173.90	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		3,526,851	0	3,526,851	96,502.00	36.55	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)		5,352,546	0	5,352,546			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		45,868	0	45,868			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		82,653	0	82,653			21.00
22.00	Physician Part A - Administrative		13,134	0	13,134			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		84,526	0	84,526			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		1,134,811	0	1,134,811			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	1,269	4	1,273	18.00	70.72	26.00
27.00	Administrative & General	5.00	1,828,237	5,783	1,834,020	37,399.00	49.04	27.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part II
Date/Time Prepared:
2/19/2020 12:03 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.)		305,803	0	305,803	2,097.00	145.83	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	486,331	1,527	487,858	19,894.00	24.52	30.00
31.00	Laundry & Linen Service	8.00	25,130	79	25,209	2,086.00	12.08	31.00
32.00	Housekeeping	9.00	601,178	-929	600,249	42,356.00	14.17	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	516,899	-374,090	142,809	8,584.00	16.64	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	374,508	374,508	22,326.00	16.77	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	887,479	-106,476	781,003	18,124.00	43.09	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	353,753	1,111	354,864	14,066.00	25.23	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: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part III
Date/Time Prepared:
2/19/2020 12:03 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)	18,000,124	40,727	18,040,851	567,259.00	31.80	1.00
2.00	Excluded area salaries (see instructions)	109,971	3,469	113,440	5,533.00	20.50	2.00
3.00	Subtotal salaries (line 1 minus line 2)	17,890,153	37,258	17,927,411	561,726.00	31.91	3.00
4.00	Subtotal other wages & related costs (see inst.)	4,869,645	0	4,869,645	116,436.00	41.82	4.00
5.00	Subtotal wage-related costs (see inst.)	6,500,491	0	6,500,491	0.00	36.26	5.00
6.00	Total (sum of lines 3 thru 5)	29,260,289	37,258	29,297,547	678,162.00	43.20	6.00
7.00	Total overhead cost (see instructions)	5,006,079	-98,483	4,907,596	166,950.00	29.40	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part IV
Date/Time Prepared:
2/19/2020 12:03 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	744,278	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)	178,256	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	3,534,043	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	19,105	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	-961	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	1,066,738	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	2,618	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	34,650	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,578,727	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part V
Date/Time Prepared:
2/19/2020 12:03 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	1,306,448	5,578,727	1.00
2.00	Hospital	1,306,448	5,578,727	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0161

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

Worksheet S-7

Date/Time Prepared:
2/19/2020 12:03 pm

		1.00	2.00	3.00	4.00
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.				1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	10/10/2002		2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	0 3.00
4.00		RUL	0	0	0 4.00
5.00		RVX	0	0	0 5.00
6.00		RVL	0	0	0 6.00
7.00		RHX	0	0	0 7.00
8.00		RHL	0	0	0 8.00
9.00		RMX	0	0	0 9.00
10.00		RML	0	0	0 10.00
11.00		RLX	0	0	0 11.00
12.00		RUC	0	0	0 12.00
13.00		RUB	0	0	0 13.00
14.00		RUA	0	0	0 14.00
15.00		RVC	0	0	0 15.00
16.00		RVB	0	0	0 16.00
17.00		RVA	0	0	0 17.00
18.00		RHC	0	0	0 18.00
19.00		RHB	0	0	0 19.00
20.00		RHA	0	0	0 20.00
21.00		RMC	0	0	0 21.00
22.00		RMB	0	0	0 22.00
23.00		RMA	0	19	19 23.00
24.00		RLB	0	0	0 24.00
25.00		RLA	0	0	0 25.00
26.00		ES3	0	0	0 26.00
27.00		ES2	0	0	0 27.00
28.00		ES1	0	9	9 28.00
29.00		HE2	0	0	0 29.00
30.00		HE1	0	0	0 30.00
31.00		HD2	0	0	0 31.00
32.00		HD1	0	0	0 32.00
33.00		HC2	0	0	0 33.00
34.00		HC1	0	0	0 34.00
35.00		HB2	0	0	0 35.00
36.00		HB1	0	0	0 36.00
37.00		LE2	0	0	0 37.00
38.00		LE1	0	0	0 38.00
39.00		LD2	0	0	0 39.00
40.00		LD1	0	0	0 40.00
41.00		LC2	0	0	0 41.00
42.00		LC1	0	0	0 42.00
43.00		LB2	0	0	0 43.00
44.00		LB1	0	0	0 44.00
45.00		CE2	0	0	0 45.00
46.00		CE1	0	0	0 46.00
47.00		CD2	0	0	0 47.00
48.00		CD1	0	0	0 48.00
49.00		CC2	0	0	0 49.00
50.00		CC1	0	0	0 50.00
51.00		CB2	0	0	0 51.00
52.00		CB1	0	12	12 52.00
53.00		CA2	0	0	0 53.00
54.00		CA1	0	46	46 54.00
55.00		SE3	0	0	0 55.00
56.00		SE2	0	0	0 56.00
57.00		SE1	0	0	0 57.00
58.00		SSC	0	0	0 58.00
59.00		SSB	0	0	0 59.00
60.00		SSA	0	0	0 60.00
61.00		IB2	0	0	0 61.00
62.00		IB1	0	0	0 62.00
63.00		IA2	0	0	0 63.00
64.00		IA1	0	0	0 64.00
65.00		BB2	0	0	0 65.00
66.00		BB1	0	0	0 66.00
67.00		BA2	0	0	0 67.00
68.00		BA1	0	0	0 68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0161

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

Worksheet S-7

Date/Time Prepared:
2/19/2020 12:03 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	86	86	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
SNF SERVICES						
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).			99914	99914	201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		0	0.00		202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		0			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0161	Period: From 10/01/2018 To 09/30/2019	Worksheet S-10 Date/Time Prepared: 2/19/2020 12:03 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)		0.188266		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		4,430,550		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0		5.00
6.00	Medicaid charges		46,145,831		6.00
7.00	Medicaid cost (line 1 times line 6)		8,687,691		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)		4,257,141		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)		4,257,141		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)	3,701,475	877,989	4,579,464	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	696,862	877,989	1,574,851	21.00
22.00	Payments received from patients for amounts previously written off as charity care	5,149	0	5,149	22.00
23.00	Cost of charity care (line 21 minus line 22)	691,713	877,989	1,569,702	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		7,735,043		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		262,978		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		404,581		27.01
28.00	Non-Medicare bad debt expense (see instructions)		7,330,462		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,521,680		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		3,091,382		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		7,348,523		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0161

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

Worksheet A

Date/Time Prepared:
2/19/2020 12:03 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		732,603	732,603	32,120	764,723	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,382,374	1,382,374	24,326	1,406,700	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,269	5,567,150	5,568,419	1,146,199	6,714,618	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,828,237	9,538,767	11,367,004	-1,402,546	9,964,458	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	793,495	793,495	-374,139	419,356	6.00
7.00	00700	OPERATION OF PLANT	486,331	971,438	1,457,769	1,527	1,459,296	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	25,130	138,689	163,819	79	163,898	8.00
9.00	00900	HOUSEKEEPING	601,178	8,039	609,217	1,879	611,096	9.00
10.00	01000	DIETARY	516,899	170,804	687,703	-496,254	191,449	10.00
11.00	01100	CAFETERIA	0	0	0	497,873	497,873	11.00
13.00	01300	NURSING ADMINISTRATION	887,479	25,260	912,739	-111,214	801,525	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	353,753	13,322	367,075	1,111	368,186	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	383,879	383,879	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	529,249	0	529,249	0	529,249	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,921,871	3,326,237	6,248,108	-105,758	6,142,350	30.00
31.00	03100	INTENSIVE CARE UNIT	943,117	190,669	1,133,786	276	1,134,062	31.00
43.00	04300	NURSERY	0	0	0	86,139	86,139	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,621,956	2,707,431	4,329,387	-2,331,839	1,997,548	50.00
53.00	05300	ANESTHESIOLOGY	951,069	271,270	1,222,339	4,645	1,226,984	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	483,976	48,602	532,578	425,809	958,387	54.00
54.10	03630	ULTRA SOUND	282,782	5,104	287,886	888	288,774	54.10
54.20	03440	MAMMOGRAPHY	131,927	8,724	140,651	414	141,065	54.20
56.00	05600	RADIOISOTOPE	84,654	131,299	215,953	71,648	287,601	56.00
57.00	05700	CT SCAN	186,447	330,696	517,143	-19,254	497,889	57.00
58.00	05800	MRI	182,864	250,775	433,639	574	434,213	58.00
60.00	06000	LABORATORY	1,072,679	1,087,576	2,160,255	3,367	2,163,622	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	117,378	117,378	0	117,378	63.00
64.00	06400	INTRAVENOUS THERAPY	156,574	22,677	179,251	492	179,743	64.00
65.00	06500	RESPIRATORY THERAPY	286,906	313,611	600,517	901	601,418	65.00
66.00	06600	PHYSICAL THERAPY	703,639	23,545	727,184	103,865	831,049	66.00
67.00	06700	OCCUPATIONAL THERAPY	257,578	8,675	266,253	38,029	304,282	67.00
68.00	06800	SPEECH PATHOLOGY	163,353	38,817	202,170	28,775	230,945	68.00
69.00	06900	ELECTROCARDIOLOGY	238,658	9,300	247,958	744	248,702	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	217,653	91,607	309,260	683	309,943	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	-88,999	-88,999	777,207	688,208	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,556,375	1,556,375	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	575,750	1,990,603	2,566,353	128,730	2,695,083	73.00
76.00	03950	DIABETES SERVICES	71,639	1,489	73,128	225	73,353	76.00
76.97	07697	CARDIAC REHABILITATION	90,669	6,395	97,064	-4,563	92,501	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	137,154	-14,888	122,266	431	122,697	90.00
91.00	09100	EMERGENCY	2,010,589	2,988,797	4,999,386	-477,343	4,522,043	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,003,029	33,209,331	52,212,360	-3,700	52,208,660	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	22,309	16,166	38,475	70	38,545	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	52,855	93,297	146,152	0	146,152	192.00
192.01	19201	CARDIAC PHASE III	0	0	0	3,521	3,521	192.01
192.02	19202	FUND DEVELOPMENT	25,184	-14,277	10,907	79	10,986	192.02
192.03	19203	PULMONARY FUNCTION	9,623	72	9,695	30	9,725	192.03
200.00		TOTAL (SUM OF LINES 118 through 199)	19,113,000	33,304,589	52,417,589	0	52,417,589	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet A
Date/Time Prepared:
2/19/2020 12:03 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	674,414	1,439,137	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	760,052	2,166,752	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-722,809	5,991,809	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,643,632	6,320,826	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	419,356	6.00
7.00	00700	OPERATION OF PLANT	0	1,459,296	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	163,898	8.00
9.00	00900	HOUSEKEEPING	0	611,096	9.00
10.00	01000	DIETARY	0	191,449	10.00
11.00	01100	CAFETERIA	-154,045	343,828	11.00
13.00	01300	NURSING ADMINISTRATION	295,510	1,097,035	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-20,488	347,698	16.00
17.00	01700	SOCIAL SERVICE	-75,578	308,301	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-529,249	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,639,949	4,502,401	30.00
31.00	03100	INTENSIVE CARE UNIT	-900	1,133,162	31.00
43.00	04300	NURSERY	0	86,139	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-2,000	1,995,548	50.00
53.00	05300	ANESTHESIOLOGY	-1,079,288	147,696	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-29,525	928,862	54.00
54.10	03630	ULTRA SOUND	0	288,774	54.10
54.20	03440	MAMMOGRAPHY	0	141,065	54.20
56.00	05600	RADIOISOTOPE	0	287,601	56.00
57.00	05700	CT SCAN	0	497,889	57.00
58.00	05800	MRI	0	434,213	58.00
60.00	06000	LABORATORY	-3,880	2,159,742	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	117,378	63.00
64.00	06400	INTRAVENOUS THERAPY	0	179,743	64.00
65.00	06500	RESPIRATORY THERAPY	0	601,418	65.00
66.00	06600	PHYSICAL THERAPY	-3,500	827,549	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	304,282	67.00
68.00	06800	SPEECH PATHOLOGY	-5	230,940	68.00
69.00	06900	ELECTROCARDIOLOGY	0	248,702	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-1,738	308,205	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	688,208	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,556,375	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-337	2,694,746	73.00
76.00	03950	DIABETES SERVICES	-125	73,228	76.00
76.97	07697	CARDIAC REHABILITATION	-20,653	71,848	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	122,697	90.00
91.00	09100	EMERGENCY	-2,283,361	2,238,682	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,481,086	43,727,574	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	38,545	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	146,152	192.00
192.01	19201	CARDIAC PHASE III	0	3,521	192.01
192.02	19202	FUND DEVELOPMENT	0	10,986	192.02
192.03	19203	PULMONARY FUNCTION	0	9,725	192.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-8,481,086	43,936,503	200.00

RECLASSIFICATIONS

Provider CCN: 14-0161

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

Worksheet A-6

Date/Time Prepared:
2/19/2020 12:03 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	49,598		1.00
	0		0	49,598		
	B - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	373,336	123,365		1.00
	0		373,336	123,365		
	C - REHAB ADMIN RECLASS					
1.00	PHYSICAL THERAPY	66.00	66,247	2,882		1.00
2.00	OCCUPATIONAL THERAPY	67.00	24,256	1,055		2.00
3.00	SPEECH PATHOLOGY	68.00	18,418	801		3.00
	0		108,921	4,738		
	D - NON-ALLOWABLE CARDIAC PHASE III COST					
1.00	CARDIAC PHASE III	192.01	3,280	231		1.00
	TOTALS		3,280	231		
	E - IMPLANT DEVICE					
1.00	IMPL. DEV. CHARGED TO	72.00	0	1,556,375		1.00
	PATIENTS					
	0		0	1,556,375		
	F - MED SUPPLIES CHARGED TO PATIENTS					
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	777,207		1.00
	PATIENT					
2.00		0.00	0	0		2.00
	0		0	777,207		
	G - DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	61,356		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
	0		0	61,356		
	H - SHORT TERM DISABILITY					
1.00	HOUSEKEEPING	9.00	0	2,808		1.00
2.00	DIETARY	10.00	0	1,201		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	4,535		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	6,064		4.00
5.00	LABORATORY	60.00	0	374		5.00
6.00	OPERATING ROOM	50.00	0	1,166		6.00
7.00	EMERGENCY	91.00	0	172		7.00
8.00	ANESTHESIOLOGY	53.00	0	980		8.00
9.00	ELECTROCARDIOLOGY	69.00	0	1,805		9.00
	0		0	19,105		
	I - NURSERY COST					
1.00	NURSERY	43.00	63,526	22,414		1.00
	0		63,526	22,414		
	J - TO RECLASS SHARED SFI COST					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	425,055		1.00
2.00	RADIOISOTOPE	56.00	0	71,382		2.00
	0		0	496,437		
	K - MINISTRY ALLOCATION RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	733,852		1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	122,298		2.00
3.00	SOCIAL SERVICE	17.00	0	383,879		3.00
4.00	PHYSICAL THERAPY	66.00	0	32,318		4.00
5.00	OCCUPATIONAL THERAPY	67.00	0	11,833		5.00
6.00	SPEECH PATHOLOGY	68.00	0	8,985		6.00
7.00	DRUGS CHARGED TO PATIENTS	73.00	0	65,566		7.00
	0		0	1,358,731		
	L - TO RECLASS ED SHARED BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	458,023		1.00
	0		0	458,023		
	M - HOSPITALIST AND PALLIATIVE RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	14,152		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,848		2.00
	TOTALS		0	21,000		
	Z - VACATION ACCRUAL RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	4	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	5,783	0		2.00
3.00	OPERATION OF PLANT	7.00	1,527	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	79	0		4.00
5.00	HOUSEKEEPING	9.00	1,879	0		5.00
6.00	DIETARY	10.00	447	0		6.00
7.00	CAFETERIA	11.00	1,172	0		7.00
8.00	NURSING ADMINISTRATION	13.00	2,445	0		8.00

RECLASSIFICATIONS

Provider CCN: 14-0161

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

Worksheet A-6

Date/Time Prepared:
2/19/2020 12:03 pm

Increases					
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
9.00 MEDICAL RECORDS & LIBRARY	16.00	1,111	0		9.00
10.00 ADULTS & PEDIATRICS	30.00	8,957	0		10.00
11.00 INTENSIVE CARE UNIT	31.00	2,947	0		11.00
12.00 NURSERY	43.00	199	0		12.00
13.00 OPERATING ROOM	50.00	5,089	0		13.00
14.00 ANESTHESIOLOGY	53.00	4,645	0		14.00
15.00 RADIOLOGY-DIAGNOSTIC	54.00	1,520	0		15.00
16.00 ULTRA SOUND	54.10	888	0		16.00
17.00 MAMMOGRAPHY	54.20	414	0		17.00
18.00 RADIOISOTOPE	56.00	266	0		18.00
19.00 CT SCAN	57.00	585	0		19.00
20.00 MRI	58.00	574	0		20.00
21.00 LABORATORY	60.00	3,367	0		21.00
22.00 INTRAVENOUS THERAPY	64.00	492	0		22.00
23.00 RESPIRATORY THERAPY	65.00	901	0		23.00
24.00 PHYSICAL THERAPY	66.00	2,418	0		24.00
25.00 OCCUPATIONAL THERAPY	67.00	885	0		25.00
26.00 SPEECH PATHOLOGY	68.00	571	0		26.00
27.00 ELECTROCARDIOLOGY	69.00	744	0		27.00
28.00 ELECTROENCEPHALOGRAPHY	70.00	683	0		28.00
29.00 DRUGS CHARGED TO PATIENTS	73.00	1,808	0		29.00
30.00 DIABETES SERVICES	76.00	225	0		30.00
31.00 CARDIAC REHABILITATION	76.97	274	0		31.00
32.00 CLINIC	90.00	431	0		32.00
33.00 EMERGENCY	91.00	6,313	0		33.00
34.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	70	0		34.00
35.00 CARDIAC PHASE III	192.01	10	0		35.00
36.00 FUND DEVELOPMENT	192.02	79	0		36.00
37.00 PULMONARY FUNCTION	192.03	30	0		37.00
0		59,832	0		
500.00 Grand Total: Increases		608,895	4,948,580		500.00

RECLASSIFICATIONS

Provider CCN: 14-0161

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

Worksheet A-6

Date/Time Prepared:
2/19/2020 12:03 pm

	Decreases						27/19/2020 12:03 pm
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	49,598	0		1.00
	0		0	49,598			
	B - CAFETERIA RECLASS						
1.00	DIETARY	10.00	373,336	123,365	0		1.00
	0		373,336	123,365			
	C - REHAB ADMIN RECLASS						
1.00	NURSING ADMINISTRATION	13.00	108,921	4,738	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		108,921	4,738			
	D - NON-ALLOWABLE CARDIAC PHASE III COST						
1.00	CARDIAC REHABILITATION	76.97	3,280	231	0		1.00
	TOTALS		3,280	231			
	E - IMPLANT DEVICE						
1.00	OPERATING ROOM	50.00	0	1,556,375	0		1.00
	0		0	1,556,375			
	F - MED SUPPLIES CHARGED TO PATIENTS						
1.00	OPERATING ROOM	50.00	0	775,881	0		1.00
2.00	CARDIAC REHABILITATION	76.97	0	1,326	0		2.00
	0		0	777,207			
	G - DRUGS CHARGED TO PATIENTS						
1.00	ADULTS & PEDIATRICS	30.00	0	7,775	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	2,671	0		2.00
3.00	OPERATING ROOM	50.00	0	4,672	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	766	0		4.00
5.00	CT SCAN	57.00	0	19,839	0		5.00
6.00	EMERGENCY	91.00	0	25,633	0		6.00
	0		0	61,356			
	H - SHORT TERM DISABILITY						
1.00	HOUSEKEEPING	9.00	2,808	0	0		1.00
2.00	DIETARY	10.00	1,201	0	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	4,535	0	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	6,064	0	0		4.00
5.00	LABORATORY	60.00	374	0	0		5.00
6.00	OPERATING ROOM	50.00	1,166	0	0		6.00
7.00	EMERGENCY	91.00	172	0	0		7.00
8.00	ANESTHESIOLOGY	53.00	980	0	0		8.00
9.00	ELECTROCARDIOLOGY	69.00	1,805	0	0		9.00
	0		19,105	0			
	I - NURSERY COST						
1.00	ADULTS & PEDIATRICS	30.00	63,526	22,414	0		1.00
	0		63,526	22,414			
	J - TO RECLASS SHARED SFI COST						
1.00	MAINTENANCE & REPAIRS	6.00	0	496,437	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	496,437			
	K - MINISTRY ALLOCATION RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,358,731	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
	0		0	1,358,731			
	L - TO RECLASS ED SHARED BENEFITS						
1.00	EMERGENCY	91.00	0	458,023	0		1.00
	0		0	458,023			
	M - HOSPITALIST AND PALLIATIVE RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	0	21,000	0		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	21,000			
	Z - VACATION ACCRUAL RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	59,832	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00

RECLASSIFICATIONS

Provider CCN: 14-0161

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

Worksheet A-6

Date/Time Prepared:
2/19/2020 12:03 pm

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
11.00	0.00	0	0	0	0	11.00
12.00	0.00	0	0	0	0	12.00
13.00	0.00	0	0	0	0	13.00
14.00	0.00	0	0	0	0	14.00
15.00	0.00	0	0	0	0	15.00
16.00	0.00	0	0	0	0	16.00
17.00	0.00	0	0	0	0	17.00
18.00	0.00	0	0	0	0	18.00
19.00	0.00	0	0	0	0	19.00
20.00	0.00	0	0	0	0	20.00
21.00	0.00	0	0	0	0	21.00
22.00	0.00	0	0	0	0	22.00
23.00	0.00	0	0	0	0	23.00
24.00	0.00	0	0	0	0	24.00
25.00	0.00	0	0	0	0	25.00
26.00	0.00	0	0	0	0	26.00
27.00	0.00	0	0	0	0	27.00
28.00	0.00	0	0	0	0	28.00
29.00	0.00	0	0	0	0	29.00
30.00	0.00	0	0	0	0	30.00
31.00	0.00	0	0	0	0	31.00
32.00	0.00	0	0	0	0	32.00
33.00	0.00	0	0	0	0	33.00
34.00	0.00	0	0	0	0	34.00
35.00	0.00	0	0	0	0	35.00
36.00	0.00	0	0	0	0	36.00
37.00	0.00	0	0	0	0	37.00
0	0	0	59,832	0	0	
500.00	Grand Total: Decreases	568,168	4,989,307			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part I
Date/Time Prepared:
2/19/2020 12:03 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	600,013	0	0	0	0	1.00
2.00	Land Improvements	2,420,505	15,595	0	15,595	196,551	2.00
3.00	Buildings and Fixtures	39,323,157	266,345	0	266,345	1,586,505	3.00
4.00	Building Improvements	7,095	0	0	0	0	4.00
5.00	Fixed Equipment	23,945,865	1,918,372	0	1,918,372	3,970,313	5.00
6.00	Movable Equipment	67,172	0	0	0	59,644	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	66,363,807	2,200,312	0	2,200,312	5,813,013	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	66,363,807	2,200,312	0	2,200,312	5,813,013	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	600,013	0				1.00
2.00	Land Improvements	2,239,549	0				2.00
3.00	Buildings and Fixtures	38,002,997	0				3.00
4.00	Building Improvements	7,095	0				4.00
5.00	Fixed Equipment	21,893,924	0				5.00
6.00	Movable Equipment	7,528	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	62,751,106	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	62,751,106	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part II
Date/Time Prepared:
2/19/2020 12:03 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	732,603	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,382,374	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,114,977	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	732,603				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,382,374				2.00
3.00	Total (sum of lines 1-2)	0	2,114,977				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part III
Date/Time Prepared:
2/19/2020 12:03 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	40,249,641	0	40,249,641	0.647610	32,120	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	21,901,453	0	21,901,453	0.352390	17,478	2.00
3.00	Total (sum of lines 1-2)	62,151,094	0	62,151,094	1.000000	49,598	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	32,120	1,281,457	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	17,478	1,912,351	0	2.00
3.00	Total (sum of lines 1-2)	0	0	49,598	3,193,808	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	125,560	32,120	0	0	1,439,137	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	236,923	17,478	0	0	2,166,752	2.00
3.00	Total (sum of lines 1-2)	362,483	49,598	0	0	3,605,889	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0161

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

Worksheet A-8

Date/Time Prepared:
2/19/2020 12:03 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)	A	-8,336	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,996,478			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	-348,631			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-141,895	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-234	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-20,488	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-12,150	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	B	-108,743	ADMINISTRATIVE & GENERAL	5.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	395,211	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	235,584	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist	A	-529,249	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	HOSPITAL ADMINISTRATION	B	-5,440	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0161

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

Worksheet A-8

Date/Time Prepared:
2/19/2020 12:03 pm

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
34.00 LOBBYING DUES INCLUDING AHA AND IHA	A	-19,672	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00 UNEMPLOYMENT COMPENSATION	A	2,618	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.00
36.00 RECRUITMENT	A	-900	INTENSIVE CARE UNIT	31.00	0	36.00
37.00 EMERGENCY MEDICAL TRANSPORTATIO	B	-34,610	EMERGENCY	91.00	0	37.00
38.00 LAB NON PATIENT INCOME	B	-1,507	LABORATORY	60.00	0	38.00
39.00 CARDIAC REHAB	B	-20,653	CARDIAC REHABILITATION	76.97	0	39.00
39.01 RADIOLOGY - SILVER RECOVERY & F	B	-161	RADIOLOGY-DIAGNOSTIC	54.00	0	39.01
40.00 CRNA EMPLOYEE BENEFITS	A	-154,157	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.00
41.00 AUDIOLOGY	B	-5	SPEECH PATHOLOGY	68.00	0	41.00
42.00 EMPLOYEE BENEFIT OFFSET - NON SHARED	A	-116,827	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	42.00
43.00 EMPLOYEE BENEFIT PART B ED SHARED	A	-454,443	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	43.00
44.00 HOSPITAL ADMIN - FARM INCOME &	B	-24,000	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00 REYNOLDS STREET PROPERTY - RENT	B	-17,647	ADMINISTRATIVE & GENERAL	5.00	0	45.00
46.00 CHAPLAINCY - RENT AND OTHER REV	B	-14,002	ADMINISTRATIVE & GENERAL	5.00	0	46.00
47.00 DIABETES SERVICES	B	-125	DIABETES SERVICES	76.00	0	47.00
49.00 MARKETING AND ADVERTISING	A	-317	ADULTS & PEDIATRICS	30.00	0	49.00
49.01 MEDICAID ASSESSMENT	A	-2,075,496	ADMINISTRATIVE & GENERAL	5.00	0	49.01
49.02 REVENUE CYCLE ADMINISTRATION	B	-30	ADMINISTRATIVE & GENERAL	5.00	0	49.02
49.03 PHYS RECRUITING MEDICAL SURG ACUTE	A	-1,800	ADULTS & PEDIATRICS	30.00	0	49.03
49.04 PHYS RECRUITING EMERGENCY SVCS	A	-900	EMERGENCY	91.00	0	49.04
49.05 PHYS RECRUITING SURGERY - GENERAL	A	-2,000	OPERATING ROOM	50.00	0	49.05
49.06 OTHER REVENUE - PHARM	B	-103	DRUGS CHARGED TO PATIENTS	73.00	0	49.06
49.07 OTHER REVENUE - PT	B	-3,500	PHYSICAL THERAPY	66.00	0	49.07
49.08 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.08
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,481,086				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: 14-0161

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

Worksheet A-8-1

Date/Time Prepared:
2/19/2020 12:03 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	1.00	CAP REL COSTS-BLDG & FIXT	MINISTRY CHARGES - BLDG	153,643	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	MINISTRY CHARGES - EQUIPMENT	741,275	453,730	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	MINISTRY CHARGES - POOLED EB	733,852	733,852	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	MINISTRY CHARGES - POOLED A&	2,325,865	4,781,169	3.01
3.02	6.00	MAINTENANCE & REPAIRS	MINISTRY CHARGES - POOLED EN	419,356	419,356	3.02
3.03	54.00	RADIOLOGY-DIAGNOSTIC	MINISTRY CHARGES - POOLED IM	425,055	425,055	3.03
3.04	60.00	LABORATORY	MINISTRY CHARGES - POOLED LA	71,382	71,382	3.04
3.05	66.00	PHYSICAL THERAPY	MINISTRY CHARGES - POOLED RE	32,318	32,318	3.05
3.07	67.00	OCCUPATIONAL THERAPY	MINISTRY CHARGES - POOLED RE	11,833	11,833	3.07
3.08	68.00	SPEECH PATHOLOGY	MINISTRY CHARGES - POOLED RE	8,985	8,985	3.08
3.09	73.00	DRUGS CHARGED TO PATIENTS	MINISTRY CHARGES - POOLED PH	312,557	312,557	3.09
3.10	1.00	CAP REL COSTS-BLDG & FIXT	MINISTRY CHARGES - INTEREST	125,560	0	3.10
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	MINISTRY CHARGES - INTEREST	236,923	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	MINISTRY CHARGES - FUNCTIONA	2,642,971	1,530,537	4.01
4.02	13.00	NURSING ADMINISTRATION	MINISTRY CHARGES - FUNCTIONA	295,510	0	4.02
4.03	17.00	SOCIAL SERVICE	MINISTRY CHARGES - FUNCTIONA	308,301	383,879	4.03
4.04	54.00	RADIOLOGY-DIAGNOSTIC	SFI MAINT COST	247,774	277,138	4.04
4.05	60.00	LABORATORY	SYSTEMS LAB	769,984	769,984	4.05
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			9,863,144	10,211,775	5.00

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

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

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

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

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

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

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

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

Provider CCN: 14-0161

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

Worksheet A-8-1

Date/Time Prepared:
2/19/2020 12:03 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	153,643	9		1.00
2.00	287,545	9		2.00
3.00	0	0		3.00
3.01	-2,455,304	0		3.01
3.02	0	0		3.02
3.03	0	0		3.03
3.04	0	0		3.04
3.05	0	0		3.05
3.07	0	0		3.07
3.08	0	0		3.08
3.09	0	0		3.09
3.10	125,560	11		3.10
4.00	236,923	11		4.00
4.01	1,112,434	0		4.01
4.02	295,510	0		4.02
4.03	-75,578	0		4.03
4.04	-29,364	0		4.04
4.05	0	0		4.05
5.00	-348,631			5.00

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

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

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

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

6.00	CATHOLIC SYSTEM		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0161

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

Worksheet A-8-2

Date/Time Prepared:
2/19/2020 12:03 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	69,696	994	68,702	211,500	416	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,637,832	1,637,832	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	1,109,904	1,060,141	49,763	239,400	266	3.00
4.00	60.00	LABORATORY	2,373	2,373	0	0	0	4.00
5.00	70.00	ELECTROENCEPHALOGRAPHY	10,000	0	10,000	179,000	96	5.00
6.00	91.00	EMERGENCY	2,262,493	2,232,493	30,000	211,500	144	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			5,092,298	4,933,833	158,465		922	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	42,300	2,115	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	30,616	1,531	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	70.00	ELECTROENCEPHALOGRAPHY	8,262	413	0	0	0	5.00
6.00	91.00	EMERGENCY	14,642	732	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			95,820	4,791	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	42,300	26,402	27,396		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,637,832		2.00
3.00	53.00	ANESTHESIOLOGY	0	30,616	19,147	1,079,288		3.00
4.00	60.00	LABORATORY	0	0	0	2,373		4.00
5.00	70.00	ELECTROENCEPHALOGRAPHY	0	8,262	1,738	1,738		5.00
6.00	91.00	EMERGENCY	0	14,642	15,358	2,247,851		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	95,820	62,645	4,996,478		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/19/2020 12:03 pm

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,439,137	1,439,137				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,166,752		2,166,752			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,991,809	0	0	5,991,809		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,320,826	375,292	961,238	573,702	8,231,058	5.00
6.00	00600	MAINTENANCE & REPAIRS	419,356	9,940	4,697	0	433,993	6.00
7.00	00700	OPERATION OF PLANT	1,459,296	94,248	86,138	152,607	1,792,289	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	163,898	6,451	0	7,886	178,235	8.00
9.00	00900	HOUSEKEEPING	611,096	27,623	18,678	187,764	845,161	9.00
10.00	01000	DIETARY	191,449	10,623	9,715	44,672	256,459	10.00
11.00	01100	CAFETERIA	343,828	26,626	7,089	117,150	494,693	11.00
13.00	01300	NURSING ADMINISTRATION	1,097,035	2,686	59,384	244,306	1,403,411	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	347,698	16,437	0	111,005	475,140	16.00
17.00	01700	SOCIAL SERVICE	308,301	0	0	0	308,301	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,502,401	145,950	147,159	895,037	5,690,547	30.00
31.00	03100	INTENSIVE CARE UNIT	1,133,162	25,648	53,827	294,521	1,507,158	31.00
43.00	04300	NURSERY	86,139	3,083	4,517	20,635	114,374	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,995,548	133,933	248,940	508,593	2,887,014	50.00
53.00	05300	ANESTHESIOLOGY	147,696	0	56,541	464,206	668,443	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	928,862	37,581	82,364	151,868	1,200,675	54.00
54.10	03630	ULTRA SOUND	288,774	2,658	4,638	88,735	384,805	54.10
54.20	03440	MAMMOGRAPHY	141,065	4,153	41,022	41,398	227,638	54.20
56.00	05600	RADIOISOTOPE	287,601	452	31,099	26,564	345,716	56.00
57.00	05700	CT SCAN	497,889	6,663	90,674	58,506	653,732	57.00
58.00	05800	MRI	434,213	11,380	33,925	57,381	536,899	58.00
60.00	06000	LABORATORY	2,159,742	20,581	46,718	336,482	2,563,523	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	117,378	0	0	0	117,378	63.00
64.00	06400	INTRAVENOUS THERAPY	179,743	0	0	49,132	228,875	64.00
65.00	06500	RESPIRATORY THERAPY	601,418	3,858	6,989	90,029	702,294	65.00
66.00	06600	PHYSICAL THERAPY	827,549	41,347	26,602	241,585	1,137,083	66.00
67.00	06700	OCCUPATIONAL THERAPY	304,282	16,059	819	88,438	409,598	67.00
68.00	06800	SPEECH PATHOLOGY	230,940	15,007	3,464	57,039	306,450	68.00
69.00	06900	ELECTROCARDIOLOGY	248,702	2,141	14,812	74,323	339,978	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	308,205	0	22,006	68,298	398,509	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	688,208	20,323	10,177	0	718,708	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,556,375	0	0	0	1,556,375	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,694,746	9,395	16,602	180,666	2,901,409	73.00
76.00	03950	DIABETES SERVICES	73,228	951	0	22,480	96,659	76.00
76.97	07697	CARDIAC REHABILITATION	71,848	12,589	17,960	27,422	129,819	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	122,697	42,343	0	43,038	208,078	90.00
91.00	09100	EMERGENCY	2,238,682	57,654	58,141	630,855	2,985,332	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	43,727,574	1,183,675	2,165,935	5,956,323	43,435,809	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	38,545	46,155	0	7,000	91,700	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	146,152	190,083	817	16,534	353,586	192.00
192.01	19201	CARDIAC PHASE III	3,521	0	0	1,029	4,550	192.01
192.02	19202	FUND DEVELOPMENT	10,986	19,224	0	7,903	38,113	192.02
192.03	19203	PULMONARY FUNCTION	9,725	0	0	3,020	12,745	192.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	43,936,503	1,439,137	2,166,752	5,991,809	43,936,503	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/19/2020 12:03 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,231,058					5.00
6.00	00600	MAINTENANCE & REPAIRS	100,047	534,040				6.00
7.00	00700	OPERATION OF PLANT	413,171	47,758	2,253,218			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	41,088	3,269	15,147	237,739		8.00
9.00	00900	HOUSEKEEPING	194,832	13,997	64,857	0	1,118,847	9.00
10.00	01000	DIETARY	59,121	5,383	24,942	0	12,841	10.00
11.00	01100	CAFETERIA	114,040	13,492	62,517	0	32,186	11.00
13.00	01300	NURSING ADMINISTRATION	323,524	1,361	6,306	0	3,246	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	109,533	8,329	38,593	0	19,869	16.00
17.00	01700	SOCIAL SERVICE	71,072	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,311,812	73,956	342,682	73,801	176,425	30.00
31.00	03100	INTENSIVE CARE UNIT	347,441	12,996	60,220	15,989	31,003	31.00
43.00	04300	NURSERY	26,366	1,562	7,238	1,383	3,726	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	665,535	67,867	314,468	53,114	161,899	50.00
53.00	05300	ANESTHESIOLOGY	154,094	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	276,788	19,043	88,238	25,120	45,428	54.00
54.10	03630	ULTRA SOUND	88,708	1,347	6,241	0	3,213	54.10
54.20	03440	MAMMOGRAPHY	52,477	2,104	9,751	0	5,020	54.20
56.00	05600	RADIOISOTOPE	79,697	229	1,062	0	547	56.00
57.00	05700	CT SCAN	150,703	3,377	15,645	0	8,055	57.00
58.00	05800	MRI	123,770	5,766	26,719	0	13,756	58.00
60.00	06000	LABORATORY	590,961	10,429	48,323	0	24,878	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	27,059	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	52,762	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	161,898	1,955	9,058	0	4,663	65.00
66.00	06600	PHYSICAL THERAPY	262,128	20,951	97,079	4,588	49,980	66.00
67.00	06700	OCCUPATIONAL THERAPY	94,423	8,137	37,705	0	19,412	67.00
68.00	06800	SPEECH PATHOLOGY	70,645	7,604	35,235	0	18,140	68.00
69.00	06900	ELECTROCARDIOLOGY	78,374	1,085	5,027	0	2,588	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	91,867	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	165,682	10,298	47,716	0	24,566	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	358,786	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	668,853	4,761	22,060	0	11,357	73.00
76.00	03950	DIABETES SERVICES	22,283	482	2,232	0	1,149	76.00
76.97	07697	CARDIAC REHABILITATION	29,927	6,379	29,557	0	15,217	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	47,968	21,456	99,420	0	51,185	90.00
91.00	09100	EMERGENCY	688,200	29,215	135,369	63,191	69,693	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,115,635	404,588	1,653,407	237,186	810,042	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	21,139	23,388	108,369	0	55,792	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	81,511	96,323	446,304	553	229,775	192.00
192.01	19201	CARDIAC PHASE III	1,049	0	0	0	0	192.01
192.02	19202	FUND DEVELOPMENT	8,786	9,741	45,138	0	23,238	192.02
192.03	19203	PULMONARY FUNCTION	2,938	0	0	0	0	192.03
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)	8,231,058	534,040	2,253,218	237,739	1,118,847	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/19/2020 12:03 pm

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			10.00	11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	358,746					10.00
11.00	01100	CAFETERIA	0	716,928				11.00
13.00	01300	NURSING ADMINISTRATION	0	27,453	1,765,301			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20,712	0	672,176		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	379,373	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	8,334	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	300,038	152,735	704,396	41,126	298,062	30.00
31.00	03100	INTENSIVE CARE UNIT	58,708	45,346	209,129	10,348	56,609	31.00
43.00	04300	NURSERY	0	3,003	13,848	1,774	24,702	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	76,445	352,552	85,957	0	50.00
53.00	05300	ANESTHESIOLOGY	0	14,584	0	10,908	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,122	0	24,127	0	54.00
54.10	03630	ULTRA SOUND	0	10,632	0	15,787	0	54.10
54.20	03440	MAMMOGRAPHY	0	6,250	0	8,669	0	54.20
56.00	05600	RADIOISOTOPE	0	3,432	0	10,295	0	56.00
57.00	05700	CT SCAN	0	8,456	0	72,508	0	57.00
58.00	05800	MRI	0	8,273	0	25,476	0	58.00
60.00	06000	LABORATORY	0	65,139	0	124,896	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	2,811	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	6,741	0	2,266	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	19,241	0	9,962	0	65.00
66.00	06600	PHYSICAL THERAPY	0	32,968	0	13,136	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,348	0	7,970	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	7,139	0	2,691	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,999	0	20,535	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	10,295	0	6,968	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	18,641	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	29,814	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,729	0	63,230	0	73.00
76.00	03950	DIABETES SERVICES	0	3,248	14,978	454	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	4,688	0	1,748	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	8,579	0	2,455	0	90.00
91.00	09100	EMERGENCY	0	101,998	470,398	57,624	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	358,746	707,889	1,765,301	672,176	379,373	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	766	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,883	0	0	0	192.00
192.01	19201	CARDIAC PHASE III	0	184	0	0	0	192.01
192.02	19202	FUND DEVELOPMENT	0	1,593	0	0	0	192.02
192.03	19203	PULMONARY FUNCTION	0	613	0	0	0	192.03
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)	358,746	716,928	1,765,301	672,176	379,373	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/19/2020 12:03 pm

Cost Center Description			NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	8,334				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	9,165,580	0	9,165,580	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,354,947	0	2,354,947	31.00
43.00	04300	NURSERY	0	197,976	0	197,976	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	4,664,851	0	4,664,851	50.00
53.00	05300	ANESTHESIOLOGY	8,334	856,363	0	856,363	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,701,541	0	1,701,541	54.00
54.10	03630	ULTRA SOUND	0	510,733	0	510,733	54.10
54.20	03440	MAMMOGRAPHY	0	311,909	0	311,909	54.20
56.00	05600	RADIOISOTOPE	0	440,978	0	440,978	56.00
57.00	05700	CT SCAN	0	912,476	0	912,476	57.00
58.00	05800	MRI	0	740,659	0	740,659	58.00
60.00	06000	LABORATORY	0	3,428,149	0	3,428,149	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	147,248	0	147,248	63.00
64.00	06400	INTRAVENOUS THERAPY	0	290,644	0	290,644	64.00
65.00	06500	RESPIRATORY THERAPY	0	909,071	0	909,071	65.00
66.00	06600	PHYSICAL THERAPY	0	1,617,913	0	1,617,913	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	589,593	0	589,593	67.00
68.00	06800	SPEECH PATHOLOGY	0	447,904	0	447,904	68.00
69.00	06900	ELECTROCARDIOLOGY	0	458,586	0	458,586	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	507,639	0	507,639	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	985,611	0	985,611	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,944,975	0	1,944,975	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,688,399	0	3,688,399	73.00
76.00	03950	DIABETES SERVICES	0	141,485	0	141,485	76.00
76.97	07697	CARDIAC REHABILITATION	0	217,335	0	217,335	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	439,141	0	439,141	90.00
91.00	09100	EMERGENCY	0	4,601,020	0	4,601,020	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,334	42,272,726	0	42,272,726	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	301,154	0	301,154	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,213,935	0	1,213,935	192.00
192.01	19201	CARDIAC PHASE III	0	5,783	0	5,783	192.01
192.02	19202	FUND DEVELOPMENT	0	126,609	0	126,609	192.02
192.03	19203	PULMONARY FUNCTION	0	16,296	0	16,296	192.03
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	8,334	43,936,503	0	43,936,503	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/19/2020 12:03 pm

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	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	96,664	375,292	961,238	1,433,194	0 5.00
6.00	00600	MAINTENANCE & REPAIRS	0	9,940	4,697	14,637	0 6.00
7.00	00700	OPERATION OF PLANT	0	94,248	86,138	180,386	0 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,451	0	6,451	0 8.00
9.00	00900	HOUSEKEEPING	0	27,623	18,678	46,301	0 9.00
10.00	01000	DIETARY	0	10,623	9,715	20,338	0 10.00
11.00	01100	CAFETERIA	0	26,626	7,089	33,715	0 11.00
13.00	01300	NURSING ADMINISTRATION	0	2,686	59,384	62,070	0 13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	16,437	0	16,437	0 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	21,981	145,950	147,159	315,090	0 30.00
31.00	03100	INTENSIVE CARE UNIT	7,110	25,648	53,827	86,585	0 31.00
43.00	04300	NURSERY	0	3,083	4,517	7,600	0 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	67,460	133,933	248,940	450,333	0 50.00
53.00	05300	ANESTHESIOLOGY	0	0	56,541	56,541	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	37,581	82,364	119,945	0 54.00
54.10	03630	ULTRA SOUND	0	2,658	4,638	7,296	0 54.10
54.20	03440	MAMMOGRAPHY	0	4,153	41,022	45,175	0 54.20
56.00	05600	RADIOISOTOPE	0	452	31,099	31,551	0 56.00
57.00	05700	CT SCAN	72,555	6,663	90,674	169,892	0 57.00
58.00	05800	MRI	215,314	11,380	33,925	260,619	0 58.00
60.00	06000	LABORATORY	100,898	20,581	46,718	168,197	0 60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0 63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	28,424	3,858	6,989	39,271	0 65.00
66.00	06600	PHYSICAL THERAPY	0	41,347	26,602	67,949	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	16,059	819	16,878	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	15,007	3,464	18,471	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,141	14,812	16,953	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	66,807	0	22,006	88,813	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	20,323	10,177	30,500	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	51,227	9,395	16,602	77,224	0 73.00
76.00	03950	DIABETES SERVICES	0	951	0	951	0 76.00
76.97	07697	CARDIAC REHABILITATION	0	12,589	17,960	30,549	0 76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	42,343	0	42,343	0 90.00
91.00	09100	EMERGENCY	0	57,654	58,141	115,795	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	0 92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	728,440	1,183,675	2,165,935	4,078,050	0 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	46,155	0	46,155	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	19,387	190,083	817	210,287	0 192.00
192.01	19201	CARDIAC PHASE III	0	0	0	0	0 192.01
192.02	19202	FUND DEVELOPMENT	0	19,224	0	19,224	0 192.02
192.03	19203	PULMONARY FUNCTION	0	0	0	0	0 192.03
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)	747,827	1,439,137	2,166,752	4,353,716	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/19/2020 12:03 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,433,194					5.00
6.00	00600	MAINTENANCE & REPAIRS	17,420	32,057				6.00
7.00	00700	OPERATION OF PLANT	71,941	2,867	255,194			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,154	196	1,716	15,517		8.00
9.00	00900	HOUSEKEEPING	33,924	840	7,346	0	88,411	9.00
10.00	01000	DIETARY	10,294	323	2,825	0	1,015	10.00
11.00	01100	CAFETERIA	19,856	810	7,080	0	2,543	11.00
13.00	01300	NURSING ADMINISTRATION	56,332	82	714	0	257	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	19,072	500	4,371	0	1,570	16.00
17.00	01700	SOCIAL SERVICE	12,375	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	228,423	4,439	38,811	4,817	13,941	30.00
31.00	03100	INTENSIVE CARE UNIT	60,496	780	6,820	1,044	2,450	31.00
43.00	04300	NURSERY	4,591	94	820	90	294	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	115,882	4,074	35,616	3,467	12,793	50.00
53.00	05300	ANESTHESIOLOGY	26,831	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	48,194	1,143	9,994	1,640	3,590	54.00
54.10	03630	ULTRA SOUND	15,446	81	707	0	254	54.10
54.20	03440	MAMMOGRAPHY	9,137	126	1,104	0	397	54.20
56.00	05600	RADIOISOTOPE	13,877	14	120	0	43	56.00
57.00	05700	CT SCAN	26,240	203	1,772	0	636	57.00
58.00	05800	MRI	21,551	346	3,026	0	1,087	58.00
60.00	06000	LABORATORY	102,897	626	5,473	0	1,966	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	4,711	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	9,187	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	28,189	117	1,026	0	368	65.00
66.00	06600	PHYSICAL THERAPY	45,641	1,258	10,995	299	3,949	66.00
67.00	06700	OCCUPATIONAL THERAPY	16,441	488	4,270	0	1,534	67.00
68.00	06800	SPEECH PATHOLOGY	12,301	456	3,991	0	1,433	68.00
69.00	06900	ELECTROCARDIOLOGY	13,646	65	569	0	205	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	15,996	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,848	618	5,404	0	1,941	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	62,471	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	116,460	286	2,498	0	897	73.00
76.00	03950	DIABETES SERVICES	3,880	29	253	0	91	76.00
76.97	07697	CARDIAC REHABILITATION	5,211	383	3,348	0	1,202	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	8,352	1,288	11,260	0	4,045	90.00
91.00	09100	EMERGENCY	119,828	1,754	15,332	4,124	5,507	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,413,095	24,286	187,261	15,481	64,008	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,681	1,404	12,274	0	4,409	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,193	5,782	50,547	36	18,158	192.00
192.01	19201	CARDIAC PHASE III	183	0	0	0	0	192.01
192.02	19202	FUND DEVELOPMENT	1,530	585	5,112	0	1,836	192.02
192.03	19203	PULMONARY FUNCTION	512	0	0	0	0	192.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,433,194	32,057	255,194	15,517	88,411	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/19/2020 12:03 pm

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			10.00	11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	34,795					10.00
11.00	01100	CAFETERIA	0	64,004				11.00
13.00	01300	NURSING ADMINISTRATION	0	2,451	121,906			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,849	0	43,799		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	12,375	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	744	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	29,101	13,637	48,644	2,679	9,722	30.00
31.00	03100	INTENSIVE CARE UNIT	5,694	4,048	14,442	674	1,847	31.00
43.00	04300	NURSERY	0	268	956	116	806	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	6,825	24,346	5,598	0	50.00
53.00	05300	ANESTHESIOLOGY	0	1,302	0	710	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,975	0	1,571	0	54.00
54.10	03630	ULTRA SOUND	0	949	0	1,028	0	54.10
54.20	03440	MAMMOGRAPHY	0	558	0	565	0	54.20
56.00	05600	RADIOISOTOPE	0	306	0	671	0	56.00
57.00	05700	CT SCAN	0	755	0	4,722	0	57.00
58.00	05800	MRI	0	739	0	1,659	0	58.00
60.00	06000	LABORATORY	0	5,815	0	8,154	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	183	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	602	0	148	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,718	0	649	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,943	0	856	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,102	0	519	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	637	0	175	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	982	0	1,337	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	919	0	454	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,214	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,942	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,493	0	4,118	0	73.00
76.00	03950	DIABETES SERVICES	0	290	1,034	30	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	419	0	114	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	766	0	160	0	90.00
91.00	09100	EMERGENCY	0	9,106	32,484	3,753	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,795	63,198	121,906	43,799	12,375	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	68	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	525	0	0	0	192.00
192.01	19201	CARDIAC PHASE III	0	16	0	0	0	192.01
192.02	19202	FUND DEVELOPMENT	0	142	0	0	0	192.02
192.03	19203	PULMONARY FUNCTION	0	55	0	0	0	192.03
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)	34,795	64,004	121,906	43,799	12,375	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/19/2020 12:03 pm

Cost Center Description			NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	744				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		709,304	0	709,304	30.00
31.00	03100	INTENSIVE CARE UNIT		184,880	0	184,880	31.00
43.00	04300	NURSERY		15,635	0	15,635	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		658,934	0	658,934	50.00
53.00	05300	ANESTHESIOLOGY		85,384	0	85,384	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		188,052	0	188,052	54.00
54.10	03630	ULTRA SOUND		25,761	0	25,761	54.10
54.20	03440	MAMMOGRAPHY		57,062	0	57,062	54.20
56.00	05600	RADIOISOTOPE		46,582	0	46,582	56.00
57.00	05700	CT SCAN		204,220	0	204,220	57.00
58.00	05800	MRI		289,027	0	289,027	58.00
60.00	06000	LABORATORY		293,128	0	293,128	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		4,894	0	4,894	63.00
64.00	06400	INTRAVENOUS THERAPY		9,937	0	9,937	64.00
65.00	06500	RESPIRATORY THERAPY		71,338	0	71,338	65.00
66.00	06600	PHYSICAL THERAPY		133,890	0	133,890	66.00
67.00	06700	OCCUPATIONAL THERAPY		41,232	0	41,232	67.00
68.00	06800	SPEECH PATHOLOGY		37,464	0	37,464	68.00
69.00	06900	ELECTROCARDIOLOGY		33,757	0	33,757	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		106,182	0	106,182	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		68,525	0	68,525	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		64,413	0	64,413	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		202,976	0	202,976	73.00
76.00	03950	DIABETES SERVICES		6,558	0	6,558	76.00
76.97	07697	CARDIAC REHABILITATION		41,226	0	41,226	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC		68,214	0	68,214	90.00
91.00	09100	EMERGENCY		307,683	0	307,683	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,956,258	0	3,956,258	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		67,991	0	67,991	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		299,528	0	299,528	192.00
192.01	19201	CARDIAC PHASE III		199	0	199	192.01
192.02	19202	FUND DEVELOPMENT		28,429	0	28,429	192.02
192.03	19203	PULMONARY FUNCTION		567	0	567	192.03
200.00		Cross Foot Adjustments	744	744	0	744	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	744	4,353,716	0	4,353,716	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0161

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

Worksheet B-1

Date/Time Prepared:
2/19/2020 12:03 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (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	155,934					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,615,567				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	19,154,729			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	40,664	716,714	1,834,020	-8,231,058	35,705,445	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,077	3,502	0	0	433,993	6.00
7.00	00700	OPERATION OF PLANT	10,212	64,226	487,858	0	1,792,289	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	699	0	25,209	0	178,235	8.00
9.00	00900	HOUSEKEEPING	2,993	13,927	600,249	0	845,161	9.00
10.00	01000	DIETARY	1,151	7,244	142,809	0	256,459	10.00
11.00	01100	CAFETERIA	2,885	5,286	374,508	0	494,693	11.00
13.00	01300	NURSING ADMINISTRATION	291	44,278	781,003	0	1,403,411	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,781	0	354,864	0	475,140	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	308,301	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,814	109,724	2,861,273	0	5,690,547	30.00
31.00	03100	INTENSIVE CARE UNIT	2,779	40,134	941,529	0	1,507,158	31.00
43.00	04300	NURSERY	334	3,368	65,965	0	114,374	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	14,512	185,614	1,625,879	0	2,887,014	50.00
53.00	05300	ANESTHESIOLOGY	0	42,158	1,483,983	0	668,443	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,072	61,412	485,496	0	1,200,675	54.00
54.10	03630	ULTRA SOUND	288	3,458	283,670	0	384,805	54.10
54.20	03440	MAMMOGRAPHY	450	30,587	132,341	0	227,638	54.20
56.00	05600	RADIOISOTOPE	49	23,188	84,920	0	345,716	56.00
57.00	05700	CT SCAN	722	67,608	187,032	0	653,732	57.00
58.00	05800	MRI	1,233	25,295	183,438	0	536,899	58.00
60.00	06000	LABORATORY	2,230	34,834	1,075,673	0	2,563,523	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	117,378	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	157,066	0	228,875	64.00
65.00	06500	RESPIRATORY THERAPY	418	5,211	287,807	0	702,294	65.00
66.00	06600	PHYSICAL THERAPY	4,480	19,835	772,304	0	1,137,083	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,740	611	282,719	0	409,598	67.00
68.00	06800	SPEECH PATHOLOGY	1,626	2,583	182,342	0	306,450	68.00
69.00	06900	ELECTROCARDIOLOGY	232	11,044	237,597	0	339,978	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	16,408	218,336	0	398,509	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,202	7,588	0	0	718,708	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,556,375	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,018	12,379	577,558	0	2,901,409	73.00
76.00	03950	DIABETES SERVICES	103	0	71,864	0	96,659	76.00
76.97	07697	CARDIAC REHABILITATION	1,364	13,391	87,663	0	129,819	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	4,588	0	137,585	0	208,078	90.00
91.00	09100	EMERGENCY	6,247	43,351	2,016,729	0	2,985,332	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	128,254	1,614,958	19,041,289	-8,231,058	35,204,751	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,001	0	22,379	0	91,700	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,596	609	52,855	0	353,586	192.00
192.01	19201	CARDIAC PHASE III	0	0	3,290	0	4,550	192.01
192.02	19202	FUND DEVELOPMENT	2,083	0	25,263	0	38,113	192.02
192.03	19203	PULMONARY FUNCTION	0	0	9,653	0	12,745	192.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,439,137	2,166,752	5,991,809		8,231,058	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.229142	1.341171	0.312811		0.230527	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		1,433,194	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.040139	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0161

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

Worksheet B-1

Date/Time Prepared:
2/19/2020 12:03 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	114,193					6.00
7.00	00700	OPERATION OF PLANT	10,212	103,981				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	699	699	253,134			8.00
9.00	00900	HOUSEKEEPING	2,993	2,993	0	100,289		9.00
10.00	01000	DIETARY	1,151	1,151	0	1,151	19,322	10.00
11.00	01100	CAFETERIA	2,885	2,885	0	2,885	0	11.00
13.00	01300	NURSING ADMINISTRATION	291	291	0	291	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,781	1,781	0	1,781	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,814	15,814	78,580	15,814	16,160	30.00
31.00	03100	INTENSIVE CARE UNIT	2,779	2,779	17,024	2,779	3,162	31.00
43.00	04300	NURSERY	334	334	1,473	334	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	14,512	14,512	56,553	14,512	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,072	4,072	26,747	4,072	0	54.00
54.10	03630	ULTRA SOUND	288	288	0	288	0	54.10
54.20	03440	MAMMOGRAPHY	450	450	0	450	0	54.20
56.00	05600	RADIOISOTOPE	49	49	0	49	0	56.00
57.00	05700	CT SCAN	722	722	0	722	0	57.00
58.00	05800	MRI	1,233	1,233	0	1,233	0	58.00
60.00	06000	LABORATORY	2,230	2,230	0	2,230	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	418	418	0	418	0	65.00
66.00	06600	PHYSICAL THERAPY	4,480	4,480	4,885	4,480	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,740	1,740	0	1,740	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,626	1,626	0	1,626	0	68.00
69.00	06900	ELECTROCARDIOLOGY	232	232	0	232	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,202	2,202	0	2,202	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	1,018	1,018	0	1,018	0	73.00
76.00	03950	DIABETES SERVICES	103	103	0	103	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,364	1,364	0	1,364	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	4,588	4,588	0	4,588	0	90.00
91.00	09100	EMERGENCY	6,247	6,247	67,283	6,247	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	86,513	76,301	252,545	72,609	19,322	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,001	5,001	0	5,001	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,596	20,596	589	20,596	0	192.00
192.01	19201	CARDIAC PHASE III	0	0	0	0	0	192.01
192.02	19202	FUND DEVELOPMENT	2,083	2,083	0	2,083	0	192.02
192.03	19203	PULMONARY FUNCTION	0	0	0	0	0	192.03
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)	534,040	2,253,218	237,739	1,118,847	358,746	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.676644	21.669517	0.939182	11.156228	18.566712	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	32,057	255,194	15,517	88,411	34,795	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.280726	2.454237	0.061300	0.881562	1.800797	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0161

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

Worksheet B-1

Date/Time Prepared:
2/19/2020 12:03 pm

Cost Center Description			CAFETERIA (FTE'S)	NURSING ADMINISTRATION (FTE'S)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATI ENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			11.00	13.00	16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	23,399					11.00
13.00	01300	NURSING ADMINISTRATION	896	12,493				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	676	0	224,536,667			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	6,266		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	272	0	0	0	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,985	4,985	13,736,028	4,923	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,480	1,480	3,456,316	935	0	31.00
43.00	04300	NURSERY	98	98	592,642	408	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,495	2,495	28,709,916	0	0	50.00
53.00	05300	ANESTHESIOLOGY	476	0	3,643,293	0	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	722	0	8,058,484	0	0	54.00
54.10	03630	ULTRA SOUND	347	0	5,273,033	0	0	54.10
54.20	03440	MAMMOGRAPHY	204	0	2,895,543	0	0	54.20
56.00	05600	RADIOISOTOPE	112	0	3,438,518	0	0	56.00
57.00	05700	CT SCAN	276	0	24,217,816	0	0	57.00
58.00	05800	MRI	270	0	8,509,055	0	0	58.00
60.00	06000	LABORATORY	2,126	0	41,743,318	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	938,888	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	220	0	756,987	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	628	0	3,327,481	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,076	0	4,387,282	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	403	0	2,661,885	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	233	0	898,768	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	359	0	6,858,787	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	336	0	2,327,310	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	6,226,038	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	9,957,985	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	546	0	21,119,014	0	0	73.00
76.00	03950	DIABETES SERVICES	106	106	151,760	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	153	0	583,953	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	280	0	820,123	0	0	90.00
91.00	09100	EMERGENCY	3,329	3,329	19,246,444	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,104	12,493	224,536,667	6,266	100	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	25	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192	0	0	0	0	192.00
192.01	19201	CARDIAC PHASE III	6	0	0	0	0	192.01
192.02	19202	FUND DEVELOPMENT	52	0	0	0	0	192.02
192.03	19203	PULMONARY FUNCTION	20	0	0	0	0	192.03
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)	716,928	1,765,301	672,176	379,373	8,334	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	30.639258	141.303210	0.002994	60.544686	83.340000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	64,004	121,906	43,799	12,375	744	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.735331	9.757944	0.000195	1.974944	7.440000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0161		Period: From 10/01/2018 To 09/30/2019		Worksheet C Part I Date/Time Prepared: 2/19/2020 12:03 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,165,580		9,165,580	0	9,165,580	30.00
31.00	03100	INTENSIVE CARE UNIT	2,354,947		2,354,947	0	2,354,947	31.00
43.00	04300	NURSERY	197,976		197,976	0	197,976	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,664,851		4,664,851	0	4,664,851	50.00
53.00	05300	ANESTHESIOLOGY	856,363		856,363	19,147	875,510	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,701,541		1,701,541	0	1,701,541	54.00
54.10	03630	ULTRA SOUND	510,733		510,733	0	510,733	54.10
54.20	03440	MAMMOGRAPHY	311,909		311,909	0	311,909	54.20
56.00	05600	RADIOISOTOPE	440,978		440,978	0	440,978	56.00
57.00	05700	CT SCAN	912,476		912,476	0	912,476	57.00
58.00	05800	MRI	740,659		740,659	0	740,659	58.00
60.00	06000	LABORATORY	3,428,149		3,428,149	0	3,428,149	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	147,248		147,248	0	147,248	63.00
64.00	06400	INTRAVENOUS THERAPY	290,644		290,644	0	290,644	64.00
65.00	06500	RESPIRATORY THERAPY	909,071	0	909,071	0	909,071	65.00
66.00	06600	PHYSICAL THERAPY	1,617,913	0	1,617,913	0	1,617,913	66.00
67.00	06700	OCCUPATIONAL THERAPY	589,593	0	589,593	0	589,593	67.00
68.00	06800	SPEECH PATHOLOGY	447,904	0	447,904	0	447,904	68.00
69.00	06900	ELECTROCARDIOLOGY	458,586		458,586	0	458,586	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	507,639		507,639	1,738	509,377	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	985,611		985,611	0	985,611	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,944,975		1,944,975	0	1,944,975	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,688,399		3,688,399	0	3,688,399	73.00
76.00	03950	DIABETES SERVICES	141,485		141,485	0	141,485	76.00
76.97	07697	CARDIAC REHABILITATION	217,335		217,335	0	217,335	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	439,141		439,141	0	439,141	90.00
91.00	09100	EMERGENCY	4,601,020		4,601,020	15,358	4,616,378	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,672,700		1,672,700		1,672,700	92.00
200.00		Subtotal (see instructions)	43,945,426	0	43,945,426	36,243	43,981,669	200.00
201.00		Less Observation Beds	1,672,700		1,672,700		1,672,700	201.00
202.00		Total (see instructions)	42,272,726	0	42,272,726	36,243	42,308,969	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/19/2020 12:03 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	10,250,329		10,250,329			30.00
31.00	03100	INTENSIVE CARE UNIT	3,456,316		3,456,316			31.00
43.00	04300	NURSERY	592,642		592,642			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,440,198	20,269,718	28,709,916	0.162482	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	2,767,627	875,666	3,643,293	0.235052	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,008,547	7,049,937	8,058,484	0.211149	0.000000	54.00
54.10	03630	ULTRA SOUND	387,303	4,885,730	5,273,033	0.096858	0.000000	54.10
54.20	03440	MAMMOGRAPHY	1,141	2,894,402	2,895,543	0.107720	0.000000	54.20
56.00	05600	RADIOISOTOPE	226,021	3,212,497	3,438,518	0.128247	0.000000	56.00
57.00	05700	CT SCAN	3,280,082	20,937,734	24,217,816	0.037678	0.000000	57.00
58.00	05800	MRI	912,149	7,596,906	8,509,055	0.087044	0.000000	58.00
60.00	06000	LABORATORY	8,694,098	33,049,220	41,743,318	0.082124	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	355,060	583,828	938,888	0.156832	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	4,895	752,092	756,987	0.383948	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	2,172,653	1,154,828	3,327,481	0.273201	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	687,088	3,700,194	4,387,282	0.368773	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	590,513	2,071,372	2,661,885	0.221495	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	110,558	788,210	898,768	0.498353	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,270,316	5,588,471	6,858,787	0.066861	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	22,000	2,305,310	2,327,310	0.218123	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,725,145	3,500,893	6,226,038	0.158305	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,437,232	2,520,753	9,957,985	0.195318	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,141,462	13,977,552	21,119,014	0.174648	0.000000	73.00
76.00	03950	DIABETES SERVICES	0	151,760	151,760	0.932294	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	45,007	538,946	583,953	0.372179	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	820,123	820,123	0.535457	0.000000	90.00
91.00	09100	EMERGENCY	2,641,896	16,604,548	19,246,444	0.239058	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,294,371	2,191,328	3,485,699	0.479875	0.000000	92.00
200.00		Subtotal (see instructions)	66,514,649	158,022,018	224,536,667			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	66,514,649	158,022,018	224,536,667			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/19/2020 12:03 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
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.162482			50.00
53.00	05300 ANESTHESIOLOGY	0.240307			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.211149			54.00
54.10	03630 ULTRA SOUND	0.096858			54.10
54.20	03440 MAMMOGRAPHY	0.107720			54.20
56.00	05600 RADIOISOTOPE	0.128247			56.00
57.00	05700 CT SCAN	0.037678			57.00
58.00	05800 MRI	0.087044			58.00
60.00	06000 LABORATORY	0.082124			60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.156832			63.00
64.00	06400 INTRAVENOUS THERAPY	0.383948			64.00
65.00	06500 RESPIRATORY THERAPY	0.273201			65.00
66.00	06600 PHYSICAL THERAPY	0.368773			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.221495			67.00
68.00	06800 SPEECH PATHOLOGY	0.498353			68.00
69.00	06900 ELECTROCARDIOLOGY	0.066861			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.218869			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.158305			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.195318			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.174648			73.00
76.00	03950 DIABETES SERVICES	0.932294			76.00
76.97	07697 CARDIAC REHABILITATION	0.372179			76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.535457			90.00
91.00	09100 EMERGENCY	0.239856			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.479875			92.00
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: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/19/2020 12:03 pm

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,165,580		9,165,580	0	9,165,580	30.00
31.00	03100	INTENSIVE CARE UNIT	2,354,947		2,354,947	0	2,354,947	31.00
43.00	04300	NURSERY	197,976		197,976	0	197,976	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,664,851		4,664,851	0	4,664,851	50.00
53.00	05300	ANESTHESIOLOGY	856,363		856,363	19,147	875,510	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,701,541		1,701,541	0	1,701,541	54.00
54.10	03630	ULTRA SOUND	510,733		510,733	0	510,733	54.10
54.20	03440	MAMMOGRAPHY	311,909		311,909	0	311,909	54.20
56.00	05600	RADIOISOTOPE	440,978		440,978	0	440,978	56.00
57.00	05700	CT SCAN	912,476		912,476	0	912,476	57.00
58.00	05800	MRI	740,659		740,659	0	740,659	58.00
60.00	06000	LABORATORY	3,428,149		3,428,149	0	3,428,149	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	147,248		147,248	0	147,248	63.00
64.00	06400	INTRAVENOUS THERAPY	290,644		290,644	0	290,644	64.00
65.00	06500	RESPIRATORY THERAPY	909,071	0	909,071	0	909,071	65.00
66.00	06600	PHYSICAL THERAPY	1,617,913	0	1,617,913	0	1,617,913	66.00
67.00	06700	OCCUPATIONAL THERAPY	589,593	0	589,593	0	589,593	67.00
68.00	06800	SPEECH PATHOLOGY	447,904	0	447,904	0	447,904	68.00
69.00	06900	ELECTROCARDIOLOGY	458,586		458,586	0	458,586	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	507,639		507,639	1,738	509,377	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	985,611		985,611	0	985,611	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,944,975		1,944,975	0	1,944,975	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,688,399		3,688,399	0	3,688,399	73.00
76.00	03950	DIABETES SERVICES	141,485		141,485	0	141,485	76.00
76.97	07697	CARDIAC REHABILITATION	217,335		217,335	0	217,335	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	439,141		439,141	0	439,141	90.00
91.00	09100	EMERGENCY	4,601,020		4,601,020	15,358	4,616,378	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,672,700		1,672,700		1,672,700	92.00
200.00		Subtotal (see instructions)	43,945,426	0	43,945,426	36,243	43,981,669	200.00
201.00		Less Observation Beds	1,672,700		1,672,700		1,672,700	201.00
202.00		Total (see instructions)	42,272,726	0	42,272,726	36,243	42,308,969	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/19/2020 12:03 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	10,250,329		10,250,329			30.00
31.00	03100	INTENSIVE CARE UNIT	3,456,316		3,456,316			31.00
43.00	04300	NURSERY	592,642		592,642			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,440,198	20,269,718	28,709,916	0.162482	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	2,767,627	875,666	3,643,293	0.235052	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,008,547	7,049,937	8,058,484	0.211149	0.000000	54.00
54.10	03630	ULTRA SOUND	387,303	4,885,730	5,273,033	0.096858	0.000000	54.10
54.20	03440	MAMMOGRAPHY	1,141	2,894,402	2,895,543	0.107720	0.000000	54.20
56.00	05600	RADIOISOTOPE	226,021	3,212,497	3,438,518	0.128247	0.000000	56.00
57.00	05700	CT SCAN	3,280,082	20,937,734	24,217,816	0.037678	0.000000	57.00
58.00	05800	MRI	912,149	7,596,906	8,509,055	0.087044	0.000000	58.00
60.00	06000	LABORATORY	8,694,098	33,049,220	41,743,318	0.082124	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	355,060	583,828	938,888	0.156832	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	4,895	752,092	756,987	0.383948	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	2,172,653	1,154,828	3,327,481	0.273201	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	687,088	3,700,194	4,387,282	0.368773	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	590,513	2,071,372	2,661,885	0.221495	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	110,558	788,210	898,768	0.498353	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,270,316	5,588,471	6,858,787	0.066861	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	22,000	2,305,310	2,327,310	0.218123	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,725,145	3,500,893	6,226,038	0.158305	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,437,232	2,520,753	9,957,985	0.195318	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,141,462	13,977,552	21,119,014	0.174648	0.000000	73.00
76.00	03950	DIABETES SERVICES	0	151,760	151,760	0.932294	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	45,007	538,946	583,953	0.372179	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	820,123	820,123	0.535457	0.000000	90.00
91.00	09100	EMERGENCY	2,641,896	16,604,548	19,246,444	0.239058	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,294,371	2,191,328	3,485,699	0.479875	0.000000	92.00
200.00		Subtotal (see instructions)	66,514,649	158,022,018	224,536,667			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	66,514,649	158,022,018	224,536,667			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/19/2020 12:03 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
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.10	03630	ULTRA SOUND	0.000000			54.10
54.20	03440	MAMMOGRAPHY	0.000000			54.20
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03950	DIABETES SERVICES	0.000000			76.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
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: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part I
Date/Time Prepared:
2/19/2020 12:03 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	709,304	0	709,304	6,022	117.79	30.00
31.00	INTENSIVE CARE UNIT	184,880		184,880	935	197.73	31.00
43.00	NURSERY	15,635		15,635	408	38.32	43.00
200.00	Total (lines 30 through 199)	909,819		909,819	7,365		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,912	343,004				
31.00	INTENSIVE CARE UNIT	559	110,531				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	3,471	453,535				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part II
Date/Time Prepared:
2/19/2020 12:03 pm

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	PPS	
						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	658,934	28,709,916	0.022951	3,646,957	83,701	50.00
53.00	05300 ANESTHESIOLOGY	85,384	3,643,293	0.023436	526,221	12,333	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	188,052	8,058,484	0.023336	615,646	14,367	54.00
54.10	03630 ULTRA SOUND	25,761	5,273,033	0.004885	214,004	1,045	54.10
54.20	03440 MAMMOGRAPHY	57,062	2,895,543	0.019707	0	0	54.20
56.00	05600 RADIOISOTOPE	46,582	3,438,518	0.013547	147,882	2,003	56.00
57.00	05700 CT SCAN	204,220	24,217,816	0.008433	1,662,846	14,023	57.00
58.00	05800 MRI	289,027	8,509,055	0.033967	568,005	19,293	58.00
60.00	06000 LABORATORY	293,128	41,743,318	0.007022	4,745,222	33,321	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	4,894	938,888	0.005213	103,810	541	63.00
64.00	06400 INTRAVENOUS THERAPY	9,937	756,987	0.013127	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	71,338	3,327,481	0.021439	1,492,547	31,999	65.00
66.00	06600 PHYSICAL THERAPY	133,890	4,387,282	0.030518	397,776	12,139	66.00
67.00	06700 OCCUPATIONAL THERAPY	41,232	2,661,885	0.015490	338,716	5,247	67.00
68.00	06800 SPEECH PATHOLOGY	37,464	898,768	0.041684	71,049	2,962	68.00
69.00	06900 ELECTROCARDIOLOGY	33,757	6,858,787	0.004922	760,874	3,745	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	106,182	2,327,310	0.045624	21,385	976	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	68,525	6,226,038	0.011006	1,268,714	13,963	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	64,413	9,957,985	0.006468	3,968,898	25,671	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	202,976	21,119,014	0.009611	3,789,649	36,422	73.00
76.00	03950 DIABETES SERVICES	6,558	151,760	0.043213	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	41,226	583,953	0.070598	30,380	2,145	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	68,214	820,123	0.083175	0	0	90.00
91.00	09100 EMERGENCY	307,683	19,246,444	0.015986	1,506,654	24,085	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	129,447	3,485,699	0.037137	789,230	29,310	92.00
200.00	Total (lines 50 through 199)	3,175,886	210,237,380		26,666,465	369,291	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0161		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part III Date/Time Prepared: 2/19/2020 12:03 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	
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	6,022	0.00		2,912	30.00	
31.00	03100	INTENSIVE CARE UNIT			0	935	0.00		559	31.00	
43.00	04300	NURSERY			0	408	0.00		0	43.00	
200.00		Total (lines 30 through 199)			0	7,365			3,471	200.00	
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0						30.00	
31.00	03100	INTENSIVE CARE UNIT		0						31.00	
43.00	04300	NURSERY		0						43.00	
200.00		Total (lines 30 through 199)		0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/19/2020 12:03 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.10	03630	ULTRA SOUND	0	0	0	0	54.10
54.20	03440	MAMMOGRAPHY	0	0	0	0	54.20
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	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
76.00	03950	DIABETES SERVICES	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/19/2020 12:03 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	28,709,916	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,643,293	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	8,058,484	0.000000	54.00
54.10	03630	ULTRA SOUND	0	0	0	5,273,033	0.000000	54.10
54.20	03440	MAMMOGRAPHY	0	0	0	2,895,543	0.000000	54.20
56.00	05600	RADIOISOTOPE	0	0	0	3,438,518	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	24,217,816	0.000000	57.00
58.00	05800	MRI	0	0	0	8,509,055	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	41,743,318	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	938,888	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	756,987	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,327,481	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,387,282	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,661,885	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	898,768	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	6,858,787	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,327,310	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,226,038	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,957,985	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	21,119,014	0.000000	73.00
76.00	03950	DIABETES SERVICES	0	0	0	151,760	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	583,953	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	820,123	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	19,246,444	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,485,699	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	210,237,380		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/19/2020 12:03 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	3,646,957	0	4,749,536	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	526,221	0	461,718	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	615,646	0	2,041,232	0	54.00
54.10	03630	ULTRA SOUND	0.000000	214,004	0	978,525	0	54.10
54.20	03440	MAMMOGRAPHY	0.000000	0	0	2,198	0	54.20
56.00	05600	RADIOISOTOPE	0.000000	147,882	0	1,479,894	0	56.00
57.00	05700	CT SCAN	0.000000	1,662,846	0	12,642,659	0	57.00
58.00	05800	MRI	0.000000	568,005	0	2,112,085	0	58.00
60.00	06000	LABORATORY	0.000000	4,745,222	0	3,824,392	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	103,810	0	165,207	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	361,274	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,492,547	0	371,731	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	397,776	0	9,171	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	338,716	0	6,350	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	71,049	0	25,201	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	760,874	0	2,073,763	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	21,385	0	666,986	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,268,714	0	632,157	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	3,968,898	0	358,325	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	3,789,649	0	578,403	0	73.00
76.00	03950	DIABETES SERVICES	0.000000	0	0	66,452	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	30,380	0	265,035	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	1,506,654	0	4,080,172	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	789,230	0	392,828	0	92.00
200.00		Total (lines 50 through 199)		26,666,465	0	38,345,294	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part V
Date/Time Prepared:
2/19/2020 12:03 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	0.162482	4,749,536	0	0	771,714	50.00	
53.00	05300 ANESTHESIOLOGY	0.235052	461,718	0	0	108,528	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.211149	2,041,232	0	0	431,004	54.00	
54.10	03630 ULTRA SOUND	0.096858	978,525	0	0	94,778	54.10	
54.20	03440 MAMMOGRAPHY	0.107720	2,198	0	0	237	54.20	
56.00	05600 RADIOISOTOPE	0.128247	1,479,894	0	0	189,792	56.00	
57.00	05700 CT SCAN	0.037678	12,642,659	0	0	476,350	57.00	
58.00	05800 MRI	0.087044	2,112,085	0	0	183,844	58.00	
60.00	06000 LABORATORY	0.082124	3,824,392	0	0	314,074	60.00	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.156832	165,207	0	0	25,910	63.00	
64.00	06400 INTRAVENOUS THERAPY	0.383948	361,274	0	0	138,710	64.00	
65.00	06500 RESPIRATORY THERAPY	0.273201	371,731	0	0	101,557	65.00	
66.00	06600 PHYSICAL THERAPY	0.368773	9,171	0	0	3,382	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0.221495	6,350	0	0	1,406	67.00	
68.00	06800 SPEECH PATHOLOGY	0.498353	25,201	0	0	12,559	68.00	
69.00	06900 ELECTROCARDIOLOGY	0.066861	2,073,763	0	0	138,654	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY	0.218123	666,986	0	0	145,485	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.158305	632,157	0	0	100,074	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.195318	358,325	0	0	69,987	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.174648	578,403	0	46,817	101,017	73.00	
76.00	03950 DIABETES SERVICES	0.932294	66,452	0	0	61,953	76.00	
76.97	07697 CARDIAC REHABILITATION	0.372179	265,035	0	0	98,640	76.97	
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.535457	0	0	0	0	90.00	
91.00	09100 EMERGENCY	0.239058	4,080,172	0	0	975,398	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.479875	392,828	0	0	188,508	92.00	
200.00	Subtotal (see instructions)		38,345,294	0	46,817	4,733,561	200.00	
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00	Net Charges (line 200 - line 201)		38,345,294	0	46,817	4,733,561	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0161		Period: From 10/01/2018 To 09/30/2019	Worksheet D Part V Date/Time Prepared: 2/19/2020 12:03 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
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.10	03630	ULTRA SOUND	0	0		54.10
54.20	03440	MAMMOGRAPHY	0	0		54.20
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,176		73.00
76.00	03950	DIABETES SERVICES	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	8,176		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	8,176		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0161

Period:

Worksheet D

Component CCN: 14-U161

From 10/01/2018
To 09/30/2019Part V
Date/Time Prepared:
2/19/2020 12:03 pm

			Title XVIII	Swing Beds - SNF		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	0.162482	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.235052	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.211149	0	0	0	0	54.00
54.10	03630	ULTRA SOUND	0.096858	0	0	0	0	54.10
54.20	03440	MAMMOGRAPHY	0.107720	0	0	0	0	54.20
56.00	05600	RADIOISOTOPE	0.128247	0	0	0	0	56.00
57.00	05700	CT SCAN	0.037678	0	0	0	0	57.00
58.00	05800	MRI	0.087044	0	0	0	0	58.00
60.00	06000	LABORATORY	0.082124	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.156832	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.383948	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.273201	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.368773	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.221495	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.498353	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.066861	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.218123	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.158305	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.195318	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.174648	0	0	0	0	73.00
76.00	03950	DIABETES SERVICES	0.932294	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.372179	0	0	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.535457	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.239058	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.479875	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0161

Period:

Worksheet D

Component CCN: 14-U161

From 10/01/2018
To 09/30/2019Part V
Date/Time Prepared:
2/19/2020 12:03 pm

			Title XVIII		Swing Beds - SNF		PPS		
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0					50.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
54.10	03630	ULTRA SOUND	0	0					54.10
54.20	03440	MAMMOGRAPHY	0	0					54.20
56.00	05600	RADIOISOTOPE	0	0					56.00
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MRI	0	0					58.00
60.00	06000	LABORATORY	0	0					60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0					63.00
64.00	06400	INTRAVENOUS THERAPY	0	0					64.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
68.00	06800	SPEECH PATHOLOGY	0	0					68.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0					70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					73.00
76.00	03950	DIABETES SERVICES	0	0					76.00
76.97	07697	CARDIAC REHABILITATION	0	0					76.97
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0					90.00
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					92.00
200.00		Subtotal (see instructions)	0	0					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	0					202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0161	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/19/2020 12:03 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)		6,154	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,022	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)		4,923	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)		132	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,912	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)		86	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		9,165,580	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		9,165,580	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		9,165,580	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)		1,522.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,432,122	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		4,432,122	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0161

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

Worksheet D-1

Date/Time Prepared:
2/19/2020 12:03 pm

Cost Center Description		Title XVIII		Hospital		PPS
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,354,947	935	2,518.66	559	1,407,931
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)					4,516,532
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					10,356,585
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					453,535
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					369,291
52.00	Total Program excludable cost (sum of lines 50 and 51)					822,826
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					9,533,759
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					1,099
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,522.02
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,672,700

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0161

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

Worksheet D-1

Date/Time Prepared:
2/19/2020 12:03 pm

Cost Center Description		Title XVIII		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	709,304	9,165,580	0.077388	1,672,700	129,447
91.00	Nursing School cost	0	9,165,580	0.000000	1,672,700	0
92.00	Allied health cost	0	9,165,580	0.000000	1,672,700	0
93.00	All other Medical Education	0	9,165,580	0.000000	1,672,700	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0161	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/19/2020 12:03 pm	
Cost Center Description			Title XVIII	Hospital	PPS	
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		4,817,408		30.00
31.00	03100	INTENSIVE CARE UNIT		1,818,121		31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.162482	3,646,957	592,565	50.00
53.00	05300	ANESTHESIOLOGY	0.240307	526,221	126,455	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.211149	615,646	129,993	54.00
54.10	03630	ULTRA SOUND	0.096858	214,004	20,728	54.10
54.20	03440	MAMMOGRAPHY	0.107720	0	0	54.20
56.00	05600	RADIOISOTOPE	0.128247	147,882	18,965	56.00
57.00	05700	CT SCAN	0.037678	1,662,846	62,653	57.00
58.00	05800	MRI	0.087044	568,005	49,441	58.00
60.00	06000	LABORATORY	0.082124	4,745,222	389,697	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.156832	103,810	16,281	63.00
64.00	06400	INTRAVENOUS THERAPY	0.383948	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.273201	1,492,547	407,765	65.00
66.00	06600	PHYSICAL THERAPY	0.368773	397,776	146,689	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.221495	338,716	75,024	67.00
68.00	06800	SPEECH PATHOLOGY	0.498353	71,049	35,407	68.00
69.00	06900	ELECTROCARDIOLOGY	0.066861	760,874	50,873	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.218869	21,385	4,681	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.158305	1,268,714	200,844	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.195318	3,968,898	775,197	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.174648	3,789,649	661,855	73.00
76.00	03950	DIABETES SERVICES	0.932294	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.372179	30,380	11,307	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.535457	0	0	90.00
91.00	09100	EMERGENCY	0.239856	1,506,654	361,380	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.479875	789,230	378,732	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		26,666,465	4,516,532	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)		26,666,465		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0161	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3
			Component CCN: 14-U161		Date/Time Prepared: 2/19/2020 12:03 pm
			Title XVIII	Swing Beds - SNF	PPS
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.162482	0	50.00
53.00	05300	ANESTHESIOLOGY	0.240307	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.211149	1,659	54.00
54.10	03630	ULTRA SOUND	0.096858	0	54.10
54.20	03440	MAMMOGRAPHY	0.107720	0	54.20
56.00	05600	RADIOISOTOPE	0.128247	0	56.00
57.00	05700	CT SCAN	0.037678	0	57.00
58.00	05800	MRI	0.087044	0	58.00
60.00	06000	LABORATORY	0.082124	18,728	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.156832	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.383948	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.273201	3,280	65.00
66.00	06600	PHYSICAL THERAPY	0.368773	11,985	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.221495	12,890	67.00
68.00	06800	SPEECH PATHOLOGY	0.498353	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.066861	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.218869	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.158305	284	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.195318	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.174648	55,758	73.00
76.00	03950	DIABETES SERVICES	0.932294	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.372179	620	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.535457	0	90.00
91.00	09100	EMERGENCY	0.239856	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.479875	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		105,204	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)		105,204	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0161	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part A Date/Time Prepared: 2/19/2020 12:03 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)		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		7,021,289	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		18,942	2.04
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		38.63	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.50	30.00
31.00	Percentage of Medicaid patient days (see instructions)		16.08	31.00
32.00	Sum of lines 30 and 31		19.58	32.00
33.00	Allowable disproportionate share percentage (see instructions)		5.48	33.00
34.00	Disproportionate share adjustment (see instructions)		96,192	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0161	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part A Date/Time Prepared: 2/19/2020 12:03 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)		0	8,272,872,447	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000048094		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	387,118	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	387,118	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		387,118		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)	7,523,541			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	9,259,728			48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			9,259,728	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			573,638	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			0	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			9,833,366	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			9,833,366	61.00
62.00	Deductibles billed to program beneficiaries			901,832	62.00
63.00	Coinsurance billed to program beneficiaries			0	63.00
64.00	Allowable bad debts (see instructions)			193,360	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			125,684	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			163,287	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			9,057,218	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)				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)			45,633	70.93
70.94	HRR adjustment amount (see instructions)			0	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0161	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part A Date/Time Prepared: 2/19/2020 12:03 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	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)	2019	1,445,210	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		113,242	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		10,434,819	71.00
71.01	Sequestration adjustment (see instructions)		208,696	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		10,260,006	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)		-33,883	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		387,613	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)			0 100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
2/19/2020 12:03 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	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	7,021,289	0		7,021,289	7,021,289	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	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	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	18,942	0		18,942	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	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	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0548	0.0548	0.0548	0.0548		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	96,192	0	0	96,192	96,192	11.00
11.01	Uncompensated care payments	36.00	387,118	0	0	387,118	387,118	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	0	12.00
13.00	Subtotal (see instructions)	47.00	7,523,541	0	0	7,523,541	7,523,541	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	9,259,728	0	0	9,259,728	9,259,728	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	9,259,728	0	0	9,259,728	9,259,728	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	573,638	0	0	573,638	573,638	16.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
2/19/2020 12:03 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
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0
17.01	Net organ aquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	0	9,833,366	9,833,366
		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	571,269	0	0	571,269	571,269
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	2,369	0	0	2,369	2,369
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	0.0000	0.0000	0.0000	0.0000	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	573,638	0	0	573,638	573,638
		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	0.146970	
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				1,445,210	1,445,210
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
2/19/2020 12:03 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	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	7,021,289		7,021,289	7,021,289	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	18,942		18,942	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	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	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0548	0.0548	0.0548		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	96,192	0	96,192	96,192	11.00
11.01	Uncompensated care payments	36.00	387,118	0	387,118	387,118	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	7,523,541	0	7,523,541	7,523,541	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	9,259,728	0	9,259,728	9,259,728	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	9,259,728	0	9,259,728	9,259,728	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	573,638	0	573,638	573,638	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			0	9,833,366	9,833,366	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
2/19/2020 12:03 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	571,269	0	571,269	571,269	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	2,369	0	2,369	2,369	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	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	573,638	0	573,638	573,638	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	1,445,210		1,445,210	1,445,210	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	45,633	0	45,633	45,633	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	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	113,242	113,242	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0161	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part B Date/Time Prepared: 2/19/2020 12:03 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		8,176	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		4,733,561	2.00
3.00	OPPS payments		5,193,198	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		8,176	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		46,817	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)		46,817	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)		46,817	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		38,641	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)		8,176	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)		5,193,198	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,044,676	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)		4,156,698	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		4,156,698	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		4,156,698	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)		211,221	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		137,294	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		180,003	36.00
37.00	Subtotal (see instructions)		4,293,992	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		4,293,992	40.00
40.01	Sequestration adjustment (see instructions)		85,880	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		4,215,067	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-6,955	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: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet E-1
Part I
Date/Time Prepared:
2/19/2020 12:03 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		10,234,606		4,215,067	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	04/09/2019	25,400		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		25,400		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		10,260,006		4,215,067	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		33,883		6,955	6.02
7.00	Total Medicare program liability (see instructions)		10,226,123		4,208,112	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0161

Period:

Worksheet E-1

Component CCN: 14-U161

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/19/2020 12:03 pm

		Title XVIII		Swing Beds - SNF		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		20,823		0	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		20,823		0	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		20,823		0	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0161	Period: From 10/01/2018 To 09/30/2019	Worksheet E-1 Part II Date/Time Prepared: 2/19/2020 12:03 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 - SWING BEDS

		Provider CCN: 14-0161	Period: From 10/01/2018 To 09/30/2019	Worksheet E-2
		Component CCN: 14-U161		Date/Time Prepared: 2/19/2020 12:03 pm
		Title XVIII	Swing Beds - SNF	PPS
			Part A	Part B
			1.00	2.00
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		22,600	0
2.00	Inpatient routine services - swing bed-NF (see instructions)			0
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)			0
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00
5.00	Program days	86		0
6.00	Interns and residents not in approved teaching program (see instructions)			0
7.00	Utilization review - physician compensation - SNF optional method only	0		0
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	22,600		0
9.00	Primary payer payments (see instructions)	0		0
10.00	Subtotal (line 8 minus line 9)	22,600		0
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		0
12.00	Subtotal (line 10 minus line 11)	22,600		0
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,352		0
14.00	80% of Part B costs (line 12 x 80%)			0
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	21,248		0
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		0
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			0
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		0
16.99	Demonstration payment adjustment amount before sequestration	0		0
17.00	Allowable bad debts (see instructions)	0		0
17.01	Adjusted reimbursable bad debts (see instructions)	0		0
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		0
19.00	Total (see instructions)	21,248		0
19.01	Sequestration adjustment (see instructions)	425		0
19.02	Demonstration payment adjustment amount after sequestration)	0		0
20.00	Interim payments	20,823		0
21.00	Tentative settlement (for contractor use only)	0		0
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0		0
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0		0
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 swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
Comparison of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

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

Provider CCN: 14-0161

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

Worksheet G

Date/Time Prepared:
2/19/2020 12:03 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	699,810	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	31,682,096	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-22,231,573	0	0	0	6.00
7.00	Inventory	835,940	0	0	0	7.00
8.00	Prepaid expenses	14,538	0	0	0	8.00
9.00	Other current assets	219,768	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	11,220,579	0	0	0	11.00
FIXED ASSETS						
12.00	Land	600,013	0	0	0	12.00
13.00	Land improvements	2,239,549	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	38,002,997	0	0	0	15.00
16.00	Accumulated depreciation	-23,884,367	0	0	0	16.00
17.00	Leasehold improvements	7,095	0	0	0	17.00
18.00	Accumulated depreciation	-2,120,517	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	21,901,453	0	0	0	23.00
24.00	Accumulated depreciation	-14,305,954	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	301,969	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	22,742,238	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	56,030,723	510,980	860,998	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	47,077	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	56,077,800	510,980	860,998	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	90,040,617	510,980	860,998	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,508,621	0	0	0	37.00
38.00	Salaries, wages, and fees payable	34,661	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	18,750	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	5,943	0	0	0	43.00
44.00	Other current liabilities	4,633,494	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,201,469	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	68,017	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	68,017	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	6,269,486	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	83,771,131				52.00
53.00	Specific purpose fund		510,980			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			860,998		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)	83,771,131	510,980	860,998	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	90,040,617	510,980	860,998	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0161

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

Worksheet G-1

Date/Time Prepared:
2/19/2020 12:03 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		76,957,202		441,193		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		17,630,108				2.00
3.00	Total (sum of line 1 and line 2)		94,587,310		441,193		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	INCREASE IN RESTRICTED ASSETS	0		0		5,278	5.00
6.00	CONTRIBUTIONS TEMP RESTRICTED	0		69,787		0	6.00
7.00	EQUITY TRANSFER	73,941		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		73,941		69,787		10.00
11.00	Subtotal (line 3 plus line 10)		94,661,251		510,980		11.00
12.00	OTHER CHANGES	371,927		0		0	12.00
13.00	EQUITY TRANSFER	10,518,193		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		10,890,120		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		83,771,131		510,980		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	855,720		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)	855,720		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00	INCREASE IN RESTRICTED ASSETS		0				5.00
6.00	CONTRIBUTIONS TEMP RESTRICTED		0				6.00
7.00	EQUITY TRANSFER		0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	5,278		0			10.00
11.00	Subtotal (line 3 plus line 10)	860,998		0			11.00
12.00	OTHER CHANGES		0				12.00
13.00	EQUITY TRANSFER		0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	860,998		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
2/19/2020 12:03 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	11,270,065		11,270,065	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	11,270,065		11,270,065	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,456,316		3,456,316	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	3,456,316		3,456,316	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	14,726,381		14,726,381	17.00
18.00	Ancillary services	51,991,280	156,263,170	208,254,450	18.00
19.00	Outpatient services	45,007	1,510,829	1,555,836	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	1,210,060	13,583,761	14,793,821	27.00
27.01	OTHER NRCC (NON REIMBURSABLE CC)	0	177,368	177,368	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	67,972,728	171,535,128	239,507,856	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		52,417,589		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		52,417,589		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0161

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

Worksheet G-3

Date/Time Prepared:
2/19/2020 12:03 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	239,507,856	1.00
2.00	Less contractual allowances and discounts on patients' accounts	173,774,509	2.00
3.00	Net patient revenues (line 1 minus line 2)	65,733,347	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	52,417,589	4.00
5.00	Net income from service to patients (line 3 minus line 4)	13,315,758	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	155,748	6.00
7.00	Income from investments	3,036,103	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	81,250	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	141,895	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	12,150	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	55,202	24.00
24.01	RENTAL OF PHYSICIAN OFFICES	73,441	24.01
24.02	RISK VALUE BASED RESERVES	753,064	24.02
25.00	Total other income (sum of lines 6-24)	4,308,853	25.00
26.00	Total (line 5 plus line 25)	17,624,611	26.00
27.00	STATE AND FEDERAL TAXES	-5,497	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-5,497	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	17,630,108	29.00

CALCULATION OF CAPITAL PAYMENT

Provider CCN: 14-0161

Period:
From 10/01/2018
To 09/30/2019Worksheet L
Parts I-III
Date/Time Prepared:
2/19/2020 12:03 pm

		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		571,269	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		2,369	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)		16.20	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		573,638	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