

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: 14-0206	Period: From 10/01/2018 To 09/30/2019	Worksheet S Parts I-III Date/Time Prepared: 2/26/2020 2:33 pm
--	-----------------------	---	--

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 2/26/2020	Time: 2:33 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 NORWEGIAN AMERICAN HOSPITAL (14-0206) 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	398,681	-96,989	0	0	1.00
2.00	Subprovider - IPF	0	22,214	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	420,895	-96,989	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: 14-0206	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part I Date/Time Prepared: 2/26/2020 2:33 pm
---	--	--	--	-----------------------	---	---

1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1044 N. FRANSISCO AVENUE			PO Box:						1.00	
2.00	City: CHICAGO			State: IL		Zip Code: 60622		County: COOK		2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
							V	XVIII	XIX		
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		NORWEGIAN AMERICAN HOSPITAL	140206	16974	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF		NORWEGIAN AMERICAN HOSP - PSYCH	14S206	16974	4	10/01/2006	N	P	O	4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
17.10	Hospital-Based (CORF) I										17.10
17.20	Hospital-Based (OPT) I										17.20
17.30	Hospital-Based (OOT) I										17.30
17.40	Hospital-Based (OSP) I										17.40
18.00	Renal Dialysis										18.00
19.00	Other										19.00
						From:	To:				
						1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)					10/01/2018	09/30/2019		20.00		
21.00	Type of Control (see instructions)					2			21.00		
						1.00	2.00		3.00		
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				Y	N				22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				Y	Y				22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N	N				22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				N	N		N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.				1	N				23.00	

Worksheet S-2
Part I
Date/Time Prepared:
2/26/2020 2:33 pm

MCRIF32 - 15.11.167.2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part I
Date/Time Prepared:
2/26/2020 2:33 pm

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	N			60.00
		Y/N	IME	Direct GME	
		1.00	2.00	3.00	
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
61.01	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
61.20	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
					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
62.01	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
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
		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part I
Date/Time Prepared:
2/26/2020 2:33 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.				Y	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)				N N 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0206	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part I Date/Time Prepared: 2/26/2020 2:33 pm
			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	Y	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	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	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	N	98.06
Rural Providers				
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00
		Physical	Occupational	Speech
		1.00	2.00	3.00
				Respiratory
				4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			109.00
			1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N		110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0206	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part I Date/Time Prepared: 2/26/2020 2:33 pm	
		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.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	2,318,516	0	0	118.01
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N			140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0206		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/26/2020 2:33 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:	Contractor's Name:		Contractor's Number:				141.00	
142.00	Street:	PO Box:						142.00	
143.00	City:	State:		Zip Code:				143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							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	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	161.00		
161.10	CORF		N	N	N	N	161.10		
161.20	OUTPATIENT PHYSICAL THERAPY		N	N	N	N	161.20		
161.30	OUTPATIENT OCCUPATIONAL THERAPY		N	N	N	N	161.30		
161.40	OUTPATIENT SPEECH PATHOLOGY		N	N	N	N	161.40		
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0206	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part II Date/Time Prepared: 2/26/2020 2:33 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)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		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	01/26/2020	Y 01/26/2020
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: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part II
Date/Time Prepared:
2/26/2020 2:33 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RAJ	SHAH		41.00
42.00	Enter the employer/company name of the cost report preparer.	STRATEGIC REIMBURSEMENT GROUP LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	630 530-7100, X107	RAJ.SHAH@SRGROUPLLC.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part II
Date/Time Prepared:
2/26/2020 2:33 pm

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/26/2020 2:33 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	161	58,765	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)		161	58,765	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,380	0.00	0	8.00
8.01 NICU	31.01	0	0	0.00	0	8.01
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)		173	63,145	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	12	4,380		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.40
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		185				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: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/26/2020 2:33 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)	6,645	3,408	27,717			1.00
2.00	HMO and other (see instructions)	3,103	13,961				2.00
3.00	HMO IPF Subprovider	8	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	6,645	3,408	27,717			7.00
8.00	INTENSIVE CARE UNIT	837	396	3,132			8.00
8.01	NICU	0	0	0			8.01
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		450	1,196			13.00
14.00	Total (see instructions)	7,482	4,254	32,045	15.56	701.26	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	737	975	2,429	0.00	6.23	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)			16			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00	25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00	25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00	25.40
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				15.56	707.49	27.00
28.00	Observation Bed Days		213	3,571			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	96	128			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: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/26/2020 2:33 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	1,244	771	6,045	1.00
2.00 HMO and other (see instructions)				518	2,984		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
8.01 NICU							8.01
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	1,244	771	6,045		14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF	0.00	0	96	148	367		16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
25.10 CMHC - CORF	0.00						25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0.00						25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00						25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00						25.40
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days				0			33.00
33.01 LTCH site neutral days and discharges				0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part II
Date/Time Prepared:
2/26/2020 2:33 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	51,685,586	0	51,685,586	1,471,597.00	35.12
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		571,388	0	571,388	3,874.00	147.49
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		3,194,133	0	3,194,133	31,470.00	101.50
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	175,021	0	175,021	6,576.00	26.62
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		1,603,219	0	1,603,219	57,897.00	27.69
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		3,253,971	0	3,253,971	48,816.00	66.66
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		65,774	0	65,774	263.00	250.09
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		13,507,865	0	13,507,865		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		536,984	0	536,984		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		80,593	0	80,593		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		515,394	0	515,394		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		60,310	0	60,310		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	3,889,074	0	3,889,074	146,307.00	26.58
27.00	Administrative & General	5.00	8,992,025	0	8,992,025	151,395.00	59.39

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part II
Date/Time Prepared:
2/26/2020 2:33 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.)		638,069	0	638,069	4,373.00	145.91	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,489,142	0	1,489,142	61,642.00	24.16	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,274,607	0	1,274,607	80,161.00	15.90	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	827,492	-325,268	502,224	31,277.00	16.06	34.00
35.00	Dietary under contract (see instructions)		596,627	0	596,627	13,692.00	43.57	35.00
36.00	Cafeteria	11.00	0	325,268	325,268	22,243.00	14.62	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,404,452	0	1,404,452	31,486.00	44.61	38.00
39.00	Central Services and Supply	14.00	560,274	0	560,274	23,044.00	24.31	39.00
40.00	Pharmacy	15.00	1,414,024	0	1,414,024	47,088.00	30.03	40.00
41.00	Medical Records & Medical Records Library	16.00	415,077	0	415,077	15,456.00	26.86	41.00
42.00	Social Service	17.00	646,124	0	646,124	21,378.00	30.22	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part III
Date/Time Prepared:
2/26/2020 2:33 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)	49,551,128	0	49,551,128	1,451,616.00	34.14	1.00
2.00	Excluded area salaries (see instructions)	1,603,219	0	1,603,219	57,897.00	27.69	2.00
3.00	Subtotal salaries (line 1 minus line 2)	47,947,909	0	47,947,909	1,393,719.00	34.40	3.00
4.00	Subtotal other wages & related costs (see inst.)	3,319,745	0	3,319,745	49,079.00	67.64	4.00
5.00	Subtotal wage-related costs (see inst.)	13,588,458	0	13,588,458	0.00	28.34	5.00
6.00	Total (sum of lines 3 thru 5)	64,856,112	0	64,856,112	1,442,798.00	44.95	6.00
7.00	Total overhead cost (see instructions)	22,146,987	0	22,146,987	649,542.00	34.10	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part IV
Date/Time Prepared:
2/26/2020 2:33 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	419,000	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)	4,281,143	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)	0	8.02
8.03	Health Insurance (Purchased)	4,521,403	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	194,260	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	70,196	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)	203,401	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	1,255,883	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	2,864,467	17.00
18.00	Medicare Taxes - Employers Portion Only	735,669	18.00
19.00	Unemployment Insurance	55,796	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	99,928	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	14,701,146	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: 14-0206

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

 Worksheet S-3
 Part V
 Date/Time Prepared:
 2/26/2020 2:33 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	3,253,971	14,701,146	1.00
2.00	Hospital	3,253,971	14,701,146	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
16.20	Hospital-Based-CMHC 20	0	0	16.20
16.30	Hospital-Based-CMHC 30	0	0	16.30
16.40	Hospital-Based-CMHC 40	0	0	16.40
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0206

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

Worksheet S-10

Date/Time Prepared:
2/26/2020 2:33 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)		0.290128	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		69,375,445	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		164,542,521	6.00
7.00	Medicaid cost (line 1 times line 6)		47,738,393	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)		0	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)		0	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	19,212,759	9,162	19,221,921
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	5,574,159	9,162	5,583,321
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	5,574,159	9,162	5,583,321
			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)		5,261,737	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		749,497	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1,153,073	27.01
28.00	Non-Medicare bad debt expense (see instructions)		4,108,664	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,595,614	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		7,178,935	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		7,178,935	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0206

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

Worksheet A

Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		452,567	452,567	3,379,372	3,831,939	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	2,116,756	2,116,756	2.00
3.00	00300	OTHER CAP REL COSTS		1,850,978	1,850,978	-1,850,978	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	447,561	931,067	1,378,628	-315	1,378,313	4.00
4.01	00401	COMMUNICATIONS	236,666	101,707	338,373	0	338,373	4.01
4.02	00402	DATA PROCESSING	1,441,097	3,181,910	4,623,007	-458,306	4,164,701	4.02
4.03	00403	ADMITTING	829,605	309,258	1,138,863	-5,302	1,133,561	4.03
4.04	00404	CASHIERING	934,145	841,909	1,776,054	-3,050	1,773,004	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	8,992,025	16,128,513	25,120,538	-147,733	24,972,805	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,489,142	4,216,279	5,705,421	-1,092,523	4,612,898	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	359,792	359,792	8.00
9.00	00900	HOUSEKEEPING	1,274,607	944,030	2,218,637	-368,780	1,849,857	9.00
10.00	01000	DIETARY	827,492	2,050,715	2,878,207	-1,144,267	1,733,940	10.00
11.00	01100	CAFETERIA	0	0	0	1,122,993	1,122,993	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,404,452	314,700	1,719,152	-28,880	1,690,272	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	560,274	504,312	1,064,586	-48,099	1,016,487	14.00
15.00	01500	PHARMACY	1,414,024	2,689,473	4,103,497	-1,891,860	2,211,637	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	415,077	862,726	1,277,803	-14,838	1,262,965	16.00
17.00	01700	SOCIAL SERVICE	646,124	344,751	990,875	-90	990,785	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	175,021	94,860	269,881	0	269,881	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,281,434	5,372,728	16,654,162	-593,377	16,060,785	30.00
31.00	03100	INTENSIVE CARE UNIT	1,971,982	1,224,368	3,196,350	-41,170	3,155,180	31.00
31.01	02060	NICU	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	723,537	1,259,547	1,983,084	-9,044	1,974,040	40.00
43.00	04300	NURSERY	1,007,491	244,241	1,251,732	259,105	1,510,837	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,071,663	3,221,969	5,293,632	-930,286	4,363,346	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,897,619	1,117,981	3,015,600	-526,060	2,489,540	52.00
53.00	05300	ANESTHESIOLOGY	40,594	2,767,270	2,807,864	-32,931	2,774,933	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,749,771	2,429,780	4,179,551	-236,445	3,943,106	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	11,424	4,210,164	4,221,588	-1,472	4,220,116	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	735,102	342,983	1,078,085	-17,646	1,060,439	65.00
66.00	06600	PHYSICAL THERAPY	495,708	106,634	602,342	-19,101	583,241	66.00
69.00	06900	ELECTROCARDIOLOGY	176,211	107,130	283,341	-49,056	234,285	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	53,953	14,768	68,721	-793	67,928	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	239,539	239,539	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,354,858	1,354,858	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,804,336	1,804,336	73.00
75.01	07501	ACUTE DIALYSIS	0	726,630	726,630	0	726,630	75.01
75.02	03650	CARD CATH LAB	443,911	1,417,729	1,861,640	-958,341	903,299	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,702,498	1,820,371	5,522,869	-36,743	5,486,126	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	136,437	146,025	282,462	-572	281,890	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	362,401	259,536	621,937	-11,224	610,713	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	2,856,856	3,043,511	5,900,367	-64,783	5,835,584	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	50,805,904	65,653,120	116,459,024	52,686	116,511,710	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0206

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

Worksheet A

Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	430,756	280,406	711,162	-15,827	695,335	192.00
192.01	19201	PROHEALTH SERVICES	4,308	1,094,135	1,098,443	-11,714	1,086,729	192.01
192.02	19202	AUXILIARY	444,618	160,821	605,439	-25,145	580,294	192.02
200.00		TOTAL (SUM OF LINES 118 through 199)	51,685,586	67,188,482	118,874,068	0	118,874,068	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0206

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

Worksheet A

Date/Time Prepared:
2/26/2020 2:33 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	0	3,831,939	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	2,116,756	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,000,690	5,379,003	4.00
4.01	00401	COMMUNICATIONS	0	338,373	4.01
4.02	00402	DATA PROCESSING	-15,219	4,149,482	4.02
4.03	00403	ADMITTING	0	1,133,561	4.03
4.04	00404	CASHIERING	0	1,773,004	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	-12,220,899	12,751,906	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-125	4,612,773	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	359,792	8.00
9.00	00900	HOUSEKEEPING	0	1,849,857	9.00
10.00	01000	DIETARY	-53,000	1,680,940	10.00
11.00	01100	CAFETERIA	-334,429	788,564	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	-2,000	1,688,272	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-16,911	999,576	14.00
15.00	01500	PHARMACY	-4,737	2,206,900	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-330	1,262,635	16.00
17.00	01700	SOCIAL SERVICE	0	990,785	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	-470	269,411	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-72,017	15,988,768	30.00
31.00	03100	INTENSIVE CARE UNIT	-90,000	3,065,180	31.00
31.01	02060	NICU	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	-942,670	1,031,370	40.00
43.00	04300	NURSERY	0	1,510,837	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-516,217	3,847,129	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,489,540	52.00
53.00	05300	ANESTHESIOLOGY	-2,635,116	139,817	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-279,189	3,663,917	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	56.01
60.00	06000	LABORATORY	0	4,220,116	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,060,439	65.00
66.00	06600	PHYSICAL THERAPY	0	583,241	66.00
69.00	06900	ELECTROCARDIOLOGY	0	234,285	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	67,928	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	239,539	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,354,858	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,804,336	73.00
75.01	07501	ACUTE DIALYSIS	0	726,630	75.01
75.02	03650	CARD CATH LAB	-272,144	631,155	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-2,161,784	3,324,342	90.00
90.01	09001	PH CLINIC	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	-60,450	221,440	90.02
90.03	09003	DENTAL CLINIC	0	0	90.03
90.04	09004	WOUND CARE THERAPY	-99,826	510,887	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	90.05
91.00	09100	EMERGENCY	-1,229,267	4,606,317	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-17,006,110	99,505,600	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	695,335	192.00
192.01	19201	PROHEALTH SERVICES	0	1,086,729	192.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0206

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

Worksheet A

Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
192.02	19202	AUXILIARY	0	580,294	192.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-17,006,110	101,867,958	200.00

RECLASSIFICATIONS

Provider CCN: 14-0206

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

Worksheet A-6

Date/Time Prepared:
2/26/2020 2:33 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	95,079		1.00
	0		0	95,079		
	B - EQUIP DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,373,024		1.00
	0		0	1,373,024		
	C - CHARGEABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	239,539		1.00
	PATIENT					
2.00	IMPL. DEV. CHARGED TO	72.00	0	1,354,858		2.00
	PATIENTS					
	0		0	1,594,397		
	D - SHARED CAFETERIA EXP					
1.00	CAFETERIA	11.00	325,268	797,725		1.00
	0		325,268	797,725		
	F - DEPRECIATION CHARGED TO DEPTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,550,071		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
34.00		0.00	0	0		34.00
	0		0	3,550,071		
	G - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,107,246		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	743,732		2.00
	0		0	1,850,978		
	H - LAUNDRY EXP					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	359,792		1.00
	0		0	359,792		
	J - NURSERY EXP					
1.00	NURSERY	43.00	201,376	73,110		1.00
	0		201,376	73,110		
	K - CHARGEABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,804,336		1.00
	0		0	1,804,336		
500.00	Grand Total: Increases		526,644	11,498,512		500.00

RECLASSIFICATIONS

Provider CCN: 14-0206

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

Worksheet A-6

Date/Time Prepared:
2/26/2020 2:33 pm

	Decreases						2/26/2020 2:33 pm
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	A - PROPERTY INSURANCE						1.00
	ADMINISTRATIVE & GENERAL	5.00	0	95,079	12		
	0		0	95,079			
1.00	B - EQUIP DEPRECIATION						1.00
	CAP REL COSTS-BLDG & FIXT	1.00	0	1,373,024	9		
	0		0	1,373,024			
1.00	C - CHARGEABLE SUPPLIES						1.00
	OPERATING ROOM	50.00	0	755,817	0		
	2.00	CARD CATH LAB	75.02	0	838,580	0	
	0		0	1,594,397			
1.00	D - SHARED CAFETERIA EXP						1.00
	DIETARY	10.00	325,268	797,725	0		
	0		325,268	797,725			
1.00	F - DEPRECIATION CHARGED TO DEPTS						1.00
	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	315	9		
	2.00	DATA PROCESSING	4.02	0	458,306	0	
3.00	ADMITTING	4.03	0	5,302	0		3.00
4.00	CASHIERING	4.04	0	3,050	0		4.00
5.00	ADMINISTRATIVE & GENERAL	5.00	0	52,654	0		5.00
6.00	OPERATION OF PLANT	7.00	0	1,092,523	0		6.00
7.00	HOUSEKEEPING	9.00	0	8,988	0		7.00
8.00	DIETARY	10.00	0	21,274	0		8.00
9.00	NURSING ADMINISTRATION	13.00	0	28,880	0		9.00
10.00	CENTRAL SERVICES & SUPPLY	14.00	0	48,099	0		10.00
11.00	PHARMACY	15.00	0	87,524	0		11.00
12.00	MEDICAL RECORDS & LIBRARY	16.00	0	14,838	0		12.00
13.00	SOCIAL SERVICE	17.00	0	90	0		13.00
14.00	ADULTS & PEDIATRICS	30.00	0	318,891	0		14.00
15.00	INTENSIVE CARE UNIT	31.00	0	41,170	0		15.00
16.00	SUBPROVIDER - IPF	40.00	0	9,044	0		16.00
17.00	NURSERY	43.00	0	15,381	0		17.00
18.00	OPERATING ROOM	50.00	0	174,469	0		18.00
19.00	DELIVERY ROOM & LABOR ROOM	52.00	0	526,060	0		19.00
20.00	ANESTHESIOLOGY	53.00	0	32,931	0		20.00
21.00	RADIOLOGY-DIAGNOSTIC	54.00	0	236,445	0		21.00
22.00	LABORATORY	60.00	0	1,472	0		22.00
23.00	RESPIRATORY THERAPY	65.00	0	17,646	0		23.00
24.00	PHYSICAL THERAPY	66.00	0	19,101	0		24.00
25.00	ELECTROCARDIOLOGY	69.00	0	49,056	0		25.00
26.00	ELECTROENCEPHALOGRAPHY	70.00	0	793	0		26.00
27.00	CARD CATH LAB	75.02	0	119,761	0		27.00
28.00	CLINIC	90.00	0	36,743	0		28.00
29.00	HEALTHWORKS CLINIC	90.02	0	572	0		29.00
30.00	WOUND CARE THERAPY	90.04	0	11,224	0		30.00
31.00	EMERGENCY	91.00	0	64,783	0		31.00
32.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	15,827	0		32.00
33.00	PROHEALTH SERVICES	192.01	0	11,714	0		33.00
34.00	AUXILIARY	192.02	0	25,145	0		34.00
	0		0	3,550,071			
1.00	G - INTEREST EXPENSE						1.00
	OTHER CAP REL COSTS	3.00	0	1,107,246	11		
	2.00	OTHER CAP REL COSTS	3.00	0	743,732	11	
	0		0	1,850,978			
1.00	H - LAUNDRY EXP						1.00
	HOUSEKEEPING	9.00	0	359,792	0		
	0		0	359,792			
1.00	J - NURSERY EXP						1.00
	ADULTS & PEDIATRICS	30.00	201,376	73,110	0		
	0		201,376	73,110			
1.00	K - CHARGEABLE DRUGS						1.00
	PHARMACY	15.00	0	1,804,336	0		
	0		0	1,804,336			
500.00	Grand Total: Decreases		526,644	11,498,512			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part I
Date/Time Prepared:
2/26/2020 2:33 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	4,840,913	0	0	0	0	1.00	
2.00	Land Improvements	3,689,647	0	0	0	0	2.00	
3.00	Buildings and Fixtures	52,740,969	849,181	0	849,181	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	26,733,310	2,672,465	0	2,672,465	0	5.00	
6.00	Movable Equipment	56,301,258	1,925,009	0	1,925,009	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	144,306,097	5,446,655	0	5,446,655	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	144,306,097	5,446,655	0	5,446,655	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	4,840,913	0				1.00	
2.00	Land Improvements	3,689,647	0				2.00	
3.00	Buildings and Fixtures	53,590,150	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	29,405,775	0				5.00	
6.00	Movable Equipment	58,226,267	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	149,752,752	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	149,752,752	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part II
Date/Time Prepared:
2/26/2020 2:33 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	452,567	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	452,567	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	452,567				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	452,567				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part III
Date/Time Prepared:
2/26/2020 2:33 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	86,685,572	0	86,685,572	0.598195	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	58,226,267	0	58,226,267	0.401805	0	2.00
3.00	Total (sum of lines 1-2)	144,911,839	0	144,911,839	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,629,614	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,373,024	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,002,638	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	1,107,246	95,079	0	0	3,831,939	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	743,732	0	0	0	2,116,756	2.00
3.00	Total (sum of lines 1-2)	1,850,978	95,079	0	0	5,948,695	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0206

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

Worksheet A-8

Date/Time Prepared:
2/26/2020 2:33 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)	B	-8,728	ADMINISTRATIVE & GENERAL	5.00	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)	A	-71,510	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-11,690,003			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-334,429	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-330	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0206

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

Worksheet A-8

Date/Time Prepared:
2/26/2020 2:33 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	
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
33.01	MISC REV	B	-17,072	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	MISC REV	B	-15,219	DATA PROCESSING	4.02	0	33.02
33.03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.03
33.04	MISC REV	B	-844,927	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	MISC REV	B	-125	OPERATION OF PLANT	7.00	0	33.05
33.06	MISC REV	B	-53,000	DIETARY	10.00	0	33.06
33.07	MISC REV	B	-2,000	NURSING ADMINISTRATION	13.00	0	33.07
33.08	MISC REV	B	-16,911	CENTRAL SERVICES & SUPPLY	14.00	0	33.08
33.09	MISC REV	B	-4,737	PHARMACY	15.00	0	33.09
33.10	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.10
33.11	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.11
33.12	MISC REV	B	-2,270	RADIOLOGY-DIAGNOSTIC	54.00	0	33.12
33.13	MISC REV	B	-151,170	CLINIC	90.00	0	33.13
33.14	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.14
33.15	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.15
33.16	MISC REV	B	0	RADIOLOGY-DIAGNOSTIC	54.00	0	33.16
33.17	MISC REV	B	0	CLINIC	90.00	0	33.17
33.18	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.18
33.19	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.19
33.20	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.20
35.00	NON ALLOW EXP	A	-215	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.00
35.01	NON ALLOW EXP	A	-97,240	ADMINISTRATIVE & GENERAL	5.00	0	35.01
35.02	NON ALLOW EXP	A	-470	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	35.02
35.03	IL MEDICAID ASSESSEMENT	A	-7,480,312	ADMINISTRATIVE & GENERAL	5.00	0	35.03
36.00	CLINIC INTEGRATION EXP	A	-35,279	ADMINISTRATIVE & GENERAL	5.00	0	36.00
38.00	LOBBYING PORTION OF DUES	A	-8,140	ADMINISTRATIVE & GENERAL	5.00	0	38.00
40.00	LOBBYING FEES	A	-190,000	ADMINISTRATIVE & GENERAL	5.00	0	40.00
42.00	QUALIFIED PENSION PLAN CONT ADJ	A	4,017,977	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	42.00
43.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-17,006,110				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0206

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

Worksheet A-8-2

Date/Time Prepared:
2/26/2020 2:33 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	AGGREGATE-ADMINISTRATIVE & GENERAL	3,790,523	3,435,836	354,687	211,500	3,007	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	72,017	72,017	0	0	0	2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	90,000	90,000	0	0	0	3.00
4.00	40.00	AGGREGATE-SUBPROVIDER - IPF	942,670	942,670	0	0	0	4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	516,217	516,217	0	0	0	5.00
6.00	53.00	AGGREGATE-ANESTHESIOLOGY	2,635,116	2,635,116	0	0	0	6.00
7.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	276,919	276,919	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	75.02	AGGREGATE-CARD CATH LAB	272,144	272,144	0	0	0	9.00
10.00	90.00	AGGREGATE-CLINIC	2,125,515	1,843,040	282,475	211,500	1,130	10.00
11.00	90.02	AGGREGATE-HEALTHWORKS CLINIC	60,450	60,450	0	0	0	11.00
12.00	90.04	AGGREGATE-WOUND CARE THERAPY	99,826	99,826	0	0	0	12.00
13.00	91.00	AGGREGATE-EMERGENCY	1,229,267	1,229,267	0	0	0	13.00
200.00			12,110,664	11,473,502	637,162		4,137	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	AGGREGATE-ADMINISTRATIVE & GENERAL	305,760	15,288	0	0	0	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	0	0	4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	5.00
6.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	0	0	6.00
7.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	75.02	AGGREGATE-CARD CATH LAB	0	0	0	0	0	9.00
10.00	90.00	AGGREGATE-CLINIC	114,901	5,745	0	0	0	10.00
11.00	90.02	AGGREGATE-HEALTHWORKS CLINIC	0	0	0	0	0	11.00
12.00	90.04	AGGREGATE-WOUND CARE THERAPY	0	0	0	0	0	12.00
13.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	13.00
200.00			420,661	21,033	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	AGGREGATE-ADMINISTRATIVE & GENERAL	0	305,760	48,927	3,484,763		1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	72,017		2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	90,000		3.00
4.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	942,670		4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	516,217		5.00
6.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	2,635,116		6.00
7.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	276,919		7.00
8.00	0.00		0	0	0	0		8.00
9.00	75.02	AGGREGATE-CARD CATH LAB	0	0	0	272,144		9.00
10.00	90.00	AGGREGATE-CLINIC	0	114,901	167,574	2,010,614		10.00
11.00	90.02	AGGREGATE-HEALTHWORKS CLINIC	0	0	0	60,450		11.00
12.00	90.04	AGGREGATE-WOUND CARE THERAPY	0	0	0	99,826		12.00
13.00	91.00	AGGREGATE-EMERGENCY	0	0	0	1,229,267		13.00
200.00			0	420,661	216,501	11,690,003		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4.01
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,831,939	3,831,939			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,116,756		2,116,756		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,379,003	44,499	188	5,423,690	4.00
4.01	00401	COMMUNICATIONS	338,373	5,938	0	25,052	369,363 4.01
4.02	00402	DATA PROCESSING	4,149,482	93,684	273,268	152,544	5,060 4.02
4.03	00403	ADMITTING	1,133,561	88,616	3,161	87,816	5,060 4.03
4.04	00404	CASHIERING	1,773,004	21,218	1,819	98,882	29,347 4.04
5.00	00500	ADMINISTRATIVE & GENERAL	12,751,906	81,086	31,395	951,833	62,738 5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0 6.00
7.00	00700	OPERATION OF PLANT	4,612,773	321,383	651,427	157,630	18,215 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	359,792	54,254	0	0	0 8.00
9.00	00900	HOUSEKEEPING	1,849,857	51,926	5,359	134,921	0 9.00
10.00	01000	DIETARY	1,680,940	109,863	7,698	53,162	11,131 10.00
11.00	01100	CAFETERIA	788,564	49,774	4,986	34,431	1,012 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	1,688,272	35,555	17,220	148,665	8,096 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	999,576	163,027	28,679	59,307	1,012 14.00
15.00	01500	PHARMACY	2,206,900	71,258	52,187	149,679	10,120 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,262,635	73,350	8,847	43,937	22,263 16.00
17.00	01700	SOCIAL SERVICE	990,785	2,254	54	68,394	8,096 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0 20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	269,411	0	0	18,526	1,012 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	1,768	0	0	0 22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	15,988,768	614,901	190,141	1,172,849	38,454 30.00
31.00	03100	INTENSIVE CARE UNIT	3,065,180	92,756	24,548	208,740	0 31.00
31.01	02060	NICU	0	0	0	0	0 31.01
40.00	04000	SUBPROVIDER - IPF	1,031,370	77,992	5,393	76,589	0 40.00
43.00	04300	NURSERY	1,510,837	57,112	9,171	127,962	3,036 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,847,129	269,413	104,028	219,292	24,287 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,489,540	47,122	313,667	200,869	2,024 52.00
53.00	05300	ANESTHESIOLOGY	139,817	9,843	19,635	4,297	3,036 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,663,917	144,078	140,982	185,219	20,239 54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0 56.01
60.00	06000	LABORATORY	4,220,116	120,310	878	1,209	24,287 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	1,060,439	36,086	10,522	77,813	5,060 65.00
66.00	06600	PHYSICAL THERAPY	583,241	38,208	11,389	52,472	3,036 66.00
69.00	06900	ELECTROCARDIOLOGY	234,285	46,813	29,250	18,652	8,096 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	67,928	6,410	473	5,711	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	239,539	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,354,858	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,804,336	0	0	0	0 73.00
75.01	07501	ACUTE DIALYSIS	726,630	0	0	0	0 75.01
75.02	03650	CARD CATH LAB	631,155	31,430	71,408	46,989	0 75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	3,324,342	116,435	21,908	391,921	7,084 90.00
90.01	09001	PH CLINIC	0	0	0	0	0 90.01
90.02	09002	HEALTHWORKS CLINIC	221,440	17,682	341	14,442	5,060 90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0 90.03
90.04	09004	WOUND CARE THERAPY	510,887	47,653	6,692	38,361	5,060 90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0 90.05
91.00	09100	EMERGENCY	4,606,317	111,278	38,627	302,407	12,143 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0 92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0 93.99
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0 99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0 99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0 99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0 99.40
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	99,505,600	3,154,975	2,085,341	5,330,573	344,064 118.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4.01
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,239	0	0	1,012
192.00	19200	PHYSICIANS' PRIVATE OFFICES	695,335	667,725	9,437	45,597	19,227
192.01	19201	PROHEALTH SERVICES	1,086,729	0	6,985	456	5,060
192.02	19202	AUXILIARY	580,294	0	14,993	47,064	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	101,867,958	3,831,939	2,116,756	5,423,690	369,363

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description			DATA PROCESSING	ADMITTING	CASHIERING	Subtotal	ADMINISTRATIVE & GENERAL	
			4.02	4.03	4.04	4A.04	5.00	
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
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING	4,674,038					4.02
4.03	00403	ADMITTING	382,421	1,700,635				4.03
4.04	00404	CASHIERING	552,386	0	2,476,656			4.04
5.00	00500	ADMINISTRATIVE & GENERAL	339,930	0	0	14,218,888	14,218,888	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	42,491	0	0	5,803,919	941,541	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	414,046	67,169	8.00
9.00	00900	HOUSEKEEPING	84,983	0	0	2,127,046	345,060	9.00
10.00	01000	DIETARY	84,983	0	0	1,947,777	315,978	10.00
11.00	01100	CAFETERIA	0	0	0	878,767	142,558	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	1,897,808	307,872	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	254,948	0	0	1,506,549	244,400	14.00
15.00	01500	PHARMACY	297,439	0	0	2,787,583	452,216	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	42,491	0	0	1,453,523	235,798	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	1,069,583	173,513	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	288,949	46,875	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	1,768	287	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	594,878	587,729	580,601	19,768,321	3,206,935	30.00
31.00	03100	INTENSIVE CARE UNIT	84,983	164,837	148,831	3,789,875	614,812	31.00
31.01	02060	NICU	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	37,601	33,950	1,262,895	204,873	40.00
43.00	04300	NURSERY	84,983	29,894	26,991	1,849,986	300,114	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	169,965	63,702	134,351	4,832,167	783,898	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	84,983	27,330	29,827	3,195,362	518,368	52.00
53.00	05300	ANESTHESIOLOGY	0	10,709	20,069	207,406	33,646	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	127,474	84,335	228,829	4,595,073	745,436	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	764,837	213,273	352,967	5,697,877	924,338	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	84,983	43,594	47,470	1,365,967	221,594	65.00
66.00	06600	PHYSICAL THERAPY	84,983	11,363	28,341	813,033	131,894	66.00
69.00	06900	ELECTROCARDIOLOGY	84,983	21,363	39,506	482,948	78,346	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	84,983	1,493	1,693	168,691	27,366	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,373	2,401	243,313	39,471	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	19,226	29,159	1,403,243	227,641	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	212,595	266,935	2,283,866	370,500	73.00
75.01	07501	ACUTE DIALYSIS	0	16,977	16,703	760,310	123,341	75.01
75.02	03650	CARD CATH LAB	0	59,449	79,472	919,903	149,231	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	254,948	96	21,116	4,137,850	671,263	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0	0	1,613	260,578	42,272	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0	5,443	48,657	662,753	107,515	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	84,983	88,253	337,174	5,581,182	905,407	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,674,038	1,700,635	2,476,656	98,678,805	13,701,528	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	10,251	1,663	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,437,321	233,169	192.00
192.01	19201	PROHEALTH SERVICES	0	0	0	1,099,230	178,323	192.01
192.02	19202	AUXILIARY	0	0	0	642,351	104,205	192.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description		DATA PROCESSING	ADMITTING	CASHIERING	Subtotal	ADMINISTRATIVE & GENERAL	
		4.02	4.03	4.04	4A.04	5.00	
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	4,674,038	1,700,635	2,476,656	101,867,958	14,218,888	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description			MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			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
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	ADMITTING						4.03
4.04	00404	CASHIERING						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	6,745,460				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	115,247	596,462			8.00
9.00	00900	HOUSEKEEPING	0	110,301	0	2,582,407		9.00
10.00	01000	DIETARY	0	233,373	0	92,434	2,589,562	10.00
11.00	01100	CAFETERIA	0	105,731	0	41,878	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	75,527	0	29,915	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	346,303	0	137,164	0	14.00
15.00	01500	PHARMACY	0	151,367	0	59,953	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	155,811	0	61,714	0	16.00
17.00	01700	SOCIAL SERVICE	0	4,789	0	1,897	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	3,756	0	1,488	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	1,306,180	190,819	517,352	2,158,666	30.00
31.00	03100	INTENSIVE CARE UNIT	0	197,033	25,441	78,041	242,684	31.00
31.01	02060	NICU	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	165,671	0	65,619	188,212	40.00
43.00	04300	NURSERY	0	121,319	31,847	48,052	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	572,289	108,017	226,672	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	100,097	90,882	39,647	0	52.00
53.00	05300	ANESTHESIOLOGY	0	20,908	0	8,281	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	306,051	42,939	121,221	0	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0	255,564	0	101,224	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	76,654	0	30,361	0	65.00
66.00	06600	PHYSICAL THERAPY	0	81,161	11,036	32,146	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	99,440	0	39,386	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	13,615	0	5,393	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.01	07501	ACUTE DIALYSIS	0	0	0	0	0	75.01
75.02	03650	CARD CATH LAB	0	66,763	0	26,443	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	247,332	22,887	97,963	0	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0	37,560	951	14,877	0	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0	101,224	3,182	40,093	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	236,377	68,461	93,624	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,307,443	596,462	2,012,838	2,589,562	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,625	0	7,773	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,418,392	0	561,796	0	192.00
192.01	19201	PROHEALTH SERVICES	0	0	0	0	0	192.01
192.02	19202	AUXILIARY	0	0	0	0	0	192.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description		MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		6.00	7.00	8.00	9.00	10.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	6,745,460	596,462	2,582,407	2,589,562	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description			CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	ADMITTING						4.03
4.04	00404	CASHIERING						4.04
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	1,168,934					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	33,528	0	2,344,650			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	27,882	0	0	2,262,298		14.00
15.00	01500	PHARMACY	55,691	0	0	0	3,506,810	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	25,134	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	27,239	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	7,577	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	362,843	0	1,145,357	96,770	259,036	30.00
31.00	03100	INTENSIVE CARE UNIT	58,811	0	185,643	18,298	115,829	31.00
31.01	02060	NICU	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	21,048	0	66,441	11,081	13,896	40.00
43.00	04300	NURSERY	37,986	0	119,906	1,532	5,744	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	64,036	0	202,136	0	177,264	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	56,780	0	179,233	18,273	138,588	52.00
53.00	05300	ANESTHESIOLOGY	3,516	0	11,099	12,371	6,088	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	66,388	0	0	6,907	3,688	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0	0	0	0	2,694	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	32,736	0	103,335	0	1,064	65.00
66.00	06600	PHYSICAL THERAPY	13,347	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	4,928	0	15,555	131	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,709	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	297,782	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,684,283	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,341,144	73.00
75.01	07501	ACUTE DIALYSIS	0	0	0	445	13,123	75.01
75.02	03650	CARD CATH LAB	10,177	0	32,126	0	31,415	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	110,713	0	0	7,850	131,387	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	7,478	0	0	416	25,338	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	15,699	0	0	24,915	39,644	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	89,912	0	283,819	80,913	193,113	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,135,158	0	2,344,650	2,261,967	3,499,055	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	21,741	0	0	331	5,325	192.00
192.01	19201	PROHEALTH SERVICES	0	0	0	0	0	192.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description			CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
192.02	19202	AUXILIARY	12,035	0	0	0	2,430	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,168,934	0	2,344,650	2,262,298	3,506,810	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV	
			16.00	17.00	19.00	20.00	21.00	
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
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	ADMITTING						4.03
4.04	00404	CASHIERING						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,931,980					16.00
17.00	01700	SOCIAL SERVICE	0	1,277,021				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			343,401	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	453,085	1,111,008	0	0	309,061	30.00
31.00	03100	INTENSIVE CARE UNIT	116,086	51,081	0	0	0	31.00
31.01	02060	NICU	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	26,481	0	0	0	0	40.00
43.00	04300	NURSERY	21,053	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	104,792	38,311	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	23,265	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	15,653	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	178,483	0	0	0	0	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	275,309	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	37,026	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	22,106	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	30,814	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,321	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,873	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,743	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	208,205	0	0	0	0	73.00
75.01	07501	ACUTE DIALYSIS	13,028	0	0	0	0	75.01
75.02	03650	CARD CATH LAB	61,987	0	0	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	16,470	0	0	0	34,340	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	1,258	0	0	0	0	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	37,951	0	0	0	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	262,991	76,621	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,931,980	1,277,021	0	0	343,401	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS	SERVICES-SALAR Y & FRINGES APPRV	
			16.00	17.00	19.00	20.00	21.00		
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	0	192.00
192.01	19201	PROHEALTH SERVICES	0	0	0	0	0	0	192.01
192.02	19202	AUXILIARY	0	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments							200.00
201.00		Negative Cost Centers	0	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,931,980	1,277,021	0	0	343,401	202.00	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			SERVICES-OTHER PRGM COSTS APPRV					
			22.00	23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	ADMITTING						4.03
4.04	00404	CASHIERING						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	7,299					22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,569	0	30,892,002	-315,630	30,576,372	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	5,493,634	0	5,493,634	31.00
31.01	02060	NICU	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	2,026,217	0	2,026,217	40.00
43.00	04300	NURSERY	0	0	2,537,539	0	2,537,539	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	7,109,582	0	7,109,582	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	4,360,495	0	4,360,495	52.00
53.00	05300	ANESTHESIOLOGY	0	0	318,968	0	318,968	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	6,066,186	0	6,066,186	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0	0	7,257,006	0	7,257,006	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	1,868,737	0	1,868,737	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,104,723	0	1,104,723	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	751,548	0	751,548	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	218,095	0	218,095	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	582,439	0	582,439	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	3,337,910	0	3,337,910	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	5,203,715	0	5,203,715	73.00
75.01	07501	ACUTE DIALYSIS	0	0	910,247	0	910,247	75.01
75.02	03650	CARD CATH LAB	0	0	1,298,045	0	1,298,045	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	730	0	5,478,785	-35,070	5,443,715	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0	0	390,728	0	390,728	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0	0	1,032,976	0	1,032,976	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	7,872,420	0	7,872,420	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,299	0	96,111,997	-350,700	95,761,297	118.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			SERVICES-OTHER					
			PRGM COSTS APPRV					
			22.00	23.00	24.00	25.00	26.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	39,312	0	39,312	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	3,678,075	0	3,678,075	192.00
192.01	19201	PROHEALTH SERVICES	0	0	1,277,553	0	1,277,553	192.01
192.02	19202	AUXILIARY	0	0	761,021	0	761,021	192.02
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,299	0	101,867,958	-350,700	101,517,258	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/26/2020 2:33 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	44,499	188	44,687	44,687 4.00
4.01	00401	COMMUNICATIONS	0	5,938	0	5,938	206 4.01
4.02	00402	DATA PROCESSING	0	93,684	273,268	366,952	1,257 4.02
4.03	00403	ADMITTING	0	88,616	3,161	91,777	723 4.03
4.04	00404	CASHIERING	0	21,218	1,819	23,037	815 4.04
5.00	00500	ADMINISTRATIVE & GENERAL	0	81,086	31,395	112,481	7,841 5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0 6.00
7.00	00700	OPERATION OF PLANT	0	321,383	651,427	972,810	1,299 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	54,254	0	54,254	0 8.00
9.00	00900	HOUSEKEEPING	0	51,926	5,359	57,285	1,111 9.00
10.00	01000	DIETARY	0	109,863	7,698	117,561	438 10.00
11.00	01100	CAFETERIA	0	49,774	4,986	54,760	284 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	0	35,555	17,220	52,775	1,225 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	163,027	28,679	191,706	489 14.00
15.00	01500	PHARMACY	0	71,258	52,187	123,445	1,233 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	73,350	8,847	82,197	362 16.00
17.00	01700	SOCIAL SERVICE	0	2,254	54	2,308	563 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0 20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	153 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	1,768	0	1,768	0 22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	614,901	190,141	805,042	9,667 30.00
31.00	03100	INTENSIVE CARE UNIT	0	92,756	24,548	117,304	1,720 31.00
31.01	02060	NICU	0	0	0	0	0 31.01
40.00	04000	SUBPROVIDER - IPF	0	77,992	5,393	83,385	631 40.00
43.00	04300	NURSERY	0	57,112	9,171	66,283	1,054 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	269,413	104,028	373,441	1,806 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	47,122	313,667	360,789	1,655 52.00
53.00	05300	ANESTHESIOLOGY	0	9,843	19,635	29,478	35 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	144,078	140,982	285,060	1,526 54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0 56.01
60.00	06000	LABORATORY	0	120,310	878	121,188	10 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0	36,086	10,522	46,608	641 65.00
66.00	06600	PHYSICAL THERAPY	0	38,208	11,389	49,597	432 66.00
69.00	06900	ELECTROCARDIOLOGY	0	46,813	29,250	76,063	154 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	6,410	473	6,883	47 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
75.01	07501	ACUTE DIALYSIS	0	0	0	0	0 75.01
75.02	03650	CARD CATH LAB	0	31,430	71,408	102,838	387 75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	116,435	21,908	138,343	3,229 90.00
90.01	09001	PH CLINIC	0	0	0	0	0 90.01
90.02	09002	HEALTHWORKS CLINIC	0	17,682	341	18,023	119 90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0 90.03
90.04	09004	WOUND CARE THERAPY	0	47,653	6,692	54,345	316 90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0 90.05
91.00	09100	EMERGENCY	0	111,278	38,627	149,905	2,491 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	0 92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0 93.99
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0 99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0 99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0 99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0 99.40
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,154,975	2,085,341	5,240,316	43,919 118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/26/2020 2:33 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
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,239	0	9,239	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	667,725	9,437	677,162	376 192.00
192.01	19201	PROHEALTH SERVICES	0	0	6,985	6,985	4 192.01
192.02	19202	AUXILIARY	0	0	14,993	14,993	388 192.02
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)	0	3,831,939	2,116,756	5,948,695	44,687 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description			COMMUNICATIONS	DATA PROCESSING	ADMITTING	CASHIERING	ADMINISTRATIVE & GENERAL	
			4.01	4.02	4.03	4.04	5.00	
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
4.01	00401	COMMUNICATIONS	6,144					4.01
4.02	00402	DATA PROCESSING	84	368,293				4.02
4.03	00403	ADMITTING	84	30,133	122,717			4.03
4.04	00404	CASHIERING	488	43,526	0	67,866		4.04
5.00	00500	ADMINISTRATIVE & GENERAL	1,044	26,785	0	0	148,151	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	303	3,348	0	0	9,809	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	700	8.00
9.00	00900	HOUSEKEEPING	0	6,696	0	0	3,595	9.00
10.00	01000	DIETARY	185	6,696	0	0	3,292	10.00
11.00	01100	CAFETERIA	17	0	0	0	1,485	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	135	0	0	0	3,207	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	17	20,089	0	0	2,546	14.00
15.00	01500	PHARMACY	168	23,437	0	0	4,711	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	370	3,348	0	0	2,456	16.00
17.00	01700	SOCIAL SERVICE	135	0	0	0	1,808	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	17	0	0	0	488	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	3	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	640	46,874	42,373	15,814	33,434	30.00
31.00	03100	INTENSIVE CARE UNIT	0	6,696	11,900	4,086	6,405	31.00
31.01	02060	NICU	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	2,715	932	2,134	40.00
43.00	04300	NURSERY	50	6,696	2,158	741	3,126	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	404	13,392	4,599	3,688	8,166	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	34	6,696	1,973	819	5,400	52.00
53.00	05300	ANESTHESIOLOGY	50	0	773	551	351	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	337	10,044	6,088	6,282	7,766	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	404	60,268	15,397	9,690	9,629	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	84	6,696	3,147	1,303	2,308	65.00
66.00	06600	PHYSICAL THERAPY	50	6,696	820	778	1,374	66.00
69.00	06900	ELECTROCARDIOLOGY	135	6,696	1,542	1,085	816	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	6,696	108	46	285	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	99	66	411	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,388	800	2,371	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	15,348	7,328	3,860	73.00
75.01	07501	ACUTE DIALYSIS	0	0	1,226	459	1,285	75.01
75.02	03650	CARD CATH LAB	0	0	4,292	2,182	1,555	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	118	20,089	7	580	6,993	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	84	0	0	44	440	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	84	0	393	1,336	1,120	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	202	6,696	6,371	9,256	9,432	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,723	368,293	122,717	67,866	142,761	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	17	0	0	0	17	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	320	0	0	0	2,429	192.00
192.01	19201	PROHEALTH SERVICES	84	0	0	0	1,858	192.01
192.02	19202	AUXILIARY	0	0	0	0	1,086	192.02

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description		COMMUNICATIONS	DATA PROCESSING	ADMITTING	CASHIERING	ADMINISTRATIVE & GENERAL	
		4.01	4.02	4.03	4.04	5.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	6,144	368,293	122,717	67,866	148,151	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description			MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			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
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	ADMITTING						4.03
4.04	00404	CASHIERING						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	987,569				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	16,873	71,827			8.00
9.00	00900	HOUSEKEEPING	0	16,149	0	84,836		9.00
10.00	01000	DIETARY	0	34,167	0	3,037	165,376	10.00
11.00	01100	CAFETERIA	0	15,480	0	1,376	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	11,058	0	983	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	50,700	0	4,506	0	14.00
15.00	01500	PHARMACY	0	22,161	0	1,970	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	22,812	0	2,027	0	16.00
17.00	01700	SOCIAL SERVICE	0	701	0	62	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	550	0	49	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	191,231	22,978	16,996	137,858	30.00
31.00	03100	INTENSIVE CARE UNIT	0	28,847	3,064	2,564	15,498	31.00
31.01	02060	NICU	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	24,255	0	2,156	12,020	40.00
43.00	04300	NURSERY	0	17,762	3,835	1,579	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	83,786	13,008	7,447	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	14,655	10,944	1,302	0	52.00
53.00	05300	ANESTHESIOLOGY	0	3,061	0	272	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	44,807	5,171	3,982	0	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0	37,416	0	3,325	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	11,222	0	997	0	65.00
66.00	06600	PHYSICAL THERAPY	0	11,882	1,329	1,056	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	14,559	0	1,294	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,993	0	177	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.01	07501	ACUTE DIALYSIS	0	0	0	0	0	75.01
75.02	03650	CARD CATH LAB	0	9,774	0	869	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	36,211	2,756	3,218	0	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0	5,499	115	489	0	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0	14,820	383	1,317	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	34,607	8,244	3,076	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	777,038	71,827	66,126	165,376	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,873	0	255	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	207,658	0	18,455	0	192.00
192.01	19201	PROHEALTH SERVICES	0	0	0	0	0	192.01
192.02	19202	AUXILIARY	0	0	0	0	0	192.02

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description		MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		6.00	7.00	8.00	9.00	10.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	987,569	71,827	84,836	165,376	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description			CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	ADMITTING						4.03
4.04	00404	CASHIERING						4.04
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	73,402					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	2,105	0	71,488			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,751	0	0	271,804		14.00
15.00	01500	PHARMACY	3,497	0	0	0	180,622	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,578	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,710	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	476	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	22,785	0	34,921	11,626	13,342	30.00
31.00	03100	INTENSIVE CARE UNIT	3,693	0	5,660	2,198	5,966	31.00
31.01	02060	NICU	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	1,322	0	2,026	1,331	716	40.00
43.00	04300	NURSERY	2,385	0	3,656	184	296	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,021	0	6,163	0	9,130	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,565	0	5,465	2,195	7,138	52.00
53.00	05300	ANESTHESIOLOGY	221	0	338	1,486	314	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,169	0	0	830	190	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0	0	0	0	139	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,056	0	3,151	0	55	65.00
66.00	06600	PHYSICAL THERAPY	838	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	309	0	474	16	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	107	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	35,777	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	202,361	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	120,582	73.00
75.01	07501	ACUTE DIALYSIS	0	0	0	53	676	75.01
75.02	03650	CARD CATH LAB	639	0	980	0	1,618	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	6,952	0	0	943	6,767	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	470	0	0	50	1,305	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	986	0	0	2,993	2,042	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	5,646	0	8,654	9,721	9,947	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	71,281	0	71,488	271,764	180,223	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,365	0	0	40	274	192.00
192.01	19201	PROHEALTH SERVICES	0	0	0	0	0	192.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description			CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
192.02	19202	AUXILIARY	756	0	0	0	125	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	73,402	0	71,488	271,804	180,622	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV	
			16.00	17.00	19.00	20.00	21.00	
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
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	ADMITTING						4.03
4.04	00404	CASHIERING						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	115,150					16.00
17.00	01700	SOCIAL SERVICE	0	7,287				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			1,134	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	26,968	6,340				30.00
31.00	03100	INTENSIVE CARE UNIT	6,922	291				31.00
31.01	02060	NICU	0	0				31.01
40.00	04000	SUBPROVIDER - IPF	1,579	0				40.00
43.00	04300	NURSERY	1,255	0				43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,248	219				50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,387	0				52.00
53.00	05300	ANESTHESIOLOGY	933	0				53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,643	0				54.00
56.01	05601	NUCLEAR MEDICINE	0	0				56.01
60.00	06000	LABORATORY	16,416	0				60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62.30
65.00	06500	RESPIRATORY THERAPY	2,208	0				65.00
66.00	06600	PHYSICAL THERAPY	1,318	0				66.00
69.00	06900	ELECTROCARDIOLOGY	1,837	0				69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	79	0				70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	112	0				71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,356	0				72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,415	0				73.00
75.01	07501	ACUTE DIALYSIS	777	0				75.01
75.02	03650	CARD CATH LAB	3,696	0				75.02
76.97	07697	CARDIAC REHABILITATION	0	0				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0				76.98
76.99	07699	LITHOTRIPSY	0	0				76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	982	0				90.00
90.01	09001	PH CLINIC	0	0				90.01
90.02	09002	HEALTHWORKS CLINIC	75	0				90.02
90.03	09003	DENTAL CLINIC	0	0				90.03
90.04	09004	WOUND CARE THERAPY	2,263	0				90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0				90.05
91.00	09100	EMERGENCY	15,681	437				91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0				93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0				99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	115,150	7,287	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS	SERVICES-SALAR Y & FRINGES APPRV	
			16.00	17.00	19.00	20.00	21.00		
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0					192.00
192.01	19201	PROHEALTH SERVICES	0	0					192.01
192.02	19202	AUXILIARY	0	0					192.02
200.00		Cross Foot Adjustments			0	0		1,134	200.00
201.00		Negative Cost Centers	0	0	0	0		0	201.00
202.00		TOTAL (sum lines 118 through 201)	115,150	7,287	0	0		1,134	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description		INTERNS & RESIDENTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		SERVICES-OTHER PRGM COSTS APPRV					
		22.00	23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
4.01	00401	COMMUNICATIONS					4.01
4.02	00402	DATA PROCESSING					4.02
4.03	00403	ADMITTING					4.03
4.04	00404	CASHIERING					4.04
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
20.00	02000	NURSING SCHOOL					20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,370				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		1,438,889	0	1,438,889	30.00
31.00	03100	INTENSIVE CARE UNIT		222,814	0	222,814	31.00
31.01	02060	NICU		0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF		135,202	0	135,202	40.00
43.00	04300	NURSERY		111,060	0	111,060	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		535,518	0	535,518	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		424,017	0	424,017	52.00
53.00	05300	ANESTHESIOLOGY		37,863	0	37,863	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		386,895	0	386,895	54.00
56.01	05601	NUCLEAR MEDICINE		0	0	0	56.01
60.00	06000	LABORATORY		273,882	0	273,882	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY		80,476	0	80,476	65.00
66.00	06600	PHYSICAL THERAPY		76,170	0	76,170	66.00
69.00	06900	ELECTROCARDIOLOGY		104,980	0	104,980	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		16,421	0	16,421	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		36,465	0	36,465	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		208,276	0	208,276	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		159,533	0	159,533	73.00
75.01	07501	ACUTE DIALYSIS		4,476	0	4,476	75.01
75.02	03650	CARD CATH LAB		128,830	0	128,830	75.02
76.97	07697	CARDIAC REHABILITATION		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	76.98
76.99	07699	LITHOTRIPSY		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC		227,188	0	227,188	90.00
90.01	09001	PH CLINIC		0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC		26,713	0	26,713	90.02
90.03	09003	DENTAL CLINIC		0	0	0	90.03
90.04	09004	WOUND CARE THERAPY		82,398	0	82,398	90.04
90.05	09005	FAMILY PRACTICE CLINIC		0	0	0	90.05
91.00	09100	EMERGENCY		280,366	0	280,366	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF		0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY		0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY		0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY		0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	4,998,432	0	4,998,432

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			SERVICES-OTHER PRGM COSTS APPRV					
			22.00	23.00	24.00	25.00	26.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN			12,401	0	12,401	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES			908,079	0	908,079	192.00
192.01	19201	PROHEALTH SERVICES			8,931	0	8,931	192.01
192.02	19202	AUXILIARY			17,348	0	17,348	192.02
200.00		Cross Foot Adjustments	2,370	0	3,504	0	3,504	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,370	0	5,948,695	0	5,948,695	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0206

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

Worksheet B-1

Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS ((NUMBER OF PHONES))	DATA PROCESSING ((MACHINE TIME))	
		BLDG & FIXT ((SQUARE FEET))	MVBLE EQUIP ((DOLLAR VALUE))				
		1.00	2.00	4.00	4.01	4.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	260,059				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,550,072			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,020	315	51,238,025		4.00
4.01	00401	COMMUNICATIONS	403	0	236,666	365	4.01
4.02	00402	DATA PROCESSING	6,358	458,306	1,441,097	5	110 4.02
4.03	00403	ADMITTING	6,014	5,302	829,605	5	9 4.03
4.04	00404	CASHIERING	1,440	3,050	934,145	29	13 4.04
5.00	00500	ADMINISTRATIVE & GENERAL	5,503	52,654	8,992,025	62	8 5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0 6.00
7.00	00700	OPERATION OF PLANT	21,811	1,092,523	1,489,142	18	1 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,682	0	0	0	0 8.00
9.00	00900	HOUSEKEEPING	3,524	8,988	1,274,607	0	2 9.00
10.00	01000	DIETARY	7,456	12,911	502,224	11	2 10.00
11.00	01100	CAFETERIA	3,378	8,363	325,268	1	0 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	2,413	28,880	1,404,452	8	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,064	48,099	560,274	1	6 14.00
15.00	01500	PHARMACY	4,836	87,524	1,414,024	10	7 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,978	14,838	415,077	22	1 16.00
17.00	01700	SOCIAL SERVICE	153	90	646,124	8	0 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0 20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	175,021	1	0 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	120	0	0	0	0 22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	41,731	318,891	11,080,058	38	14 30.00
31.00	03100	INTENSIVE CARE UNIT	6,295	41,170	1,971,982	0	2 31.00
31.01	02060	NICU	0	0	0	0	0 31.01
40.00	04000	SUBPROVIDER - IPF	5,293	9,044	723,537	0	0 40.00
43.00	04300	NURSERY	3,876	15,381	1,208,867	3	2 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	18,284	174,469	2,071,663	24	4 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,198	526,060	1,897,619	2	2 52.00
53.00	05300	ANESTHESIOLOGY	668	32,931	40,594	3	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,778	236,445	1,749,771	20	3 54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0 56.01
60.00	06000	LABORATORY	8,165	1,472	11,424	24	18 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	2,449	17,646	735,102	5	2 65.00
66.00	06600	PHYSICAL THERAPY	2,593	19,101	495,708	3	2 66.00
69.00	06900	ELECTROCARDIOLOGY	3,177	49,056	176,211	8	2 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	435	793	53,953	0	2 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
75.01	07501	ACUTE DIALYSIS	0	0	0	0	0 75.01
75.02	03650	CARD CATH LAB	2,133	119,761	443,911	0	0 75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	7,902	36,743	3,702,498	7	6 90.00
90.01	09001	PH CLINIC	0	0	0	0	0 90.01
90.02	09002	HEALTHWORKS CLINIC	1,200	572	136,437	5	0 90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0 90.03
90.04	09004	WOUND CARE THERAPY	3,234	11,224	362,401	5	0 90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0 90.05
91.00	09100	EMERGENCY	7,552	64,783	2,856,856	12	2 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0 93.99
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0 99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0 99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0 99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0 99.40
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	214,116	3,497,385	50,358,343	340	110 118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0206

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

Worksheet B-1

Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER OF PHONES))	DATA PROCESSING (MACHINE TIME))	
			BLDG & FIXT (SQUARE FEET))	MVBLE EQUIP (DOLLAR VALUE))				
			1.00	2.00	4.00	4.01	4.02	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	627	0	0	1	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	45,316	15,827	430,756	19	0	192.00
192.01	19201	PROHEALTH SERVICES	0	11,714	4,308	5	0	192.01
192.02	19202	AUXILIARY	0	25,146	444,618	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,831,939	2,116,756	5,423,690	369,363	4,674,038	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.734883	0.596257	0.105853	1,011.953425	42,491.254545	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			44,687	6,144	368,293	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000872	16.832877	3,348.118182	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: 14-0206

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

Worksheet B-1

Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description			ADMITTING (INPATIENT REVENUE)	CASHIERING (GROSS REVENUE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
			4.03	4.04	5A	5.00	6.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	ADMITTING	204,616,626					4.03
4.04	00404	CASHIERING	0	330,065,156				4.04
5.00	00500	ADMINISTRATIVE & GENERAL	0	0	-14,218,888	87,649,070		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	5,803,919	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	414,046	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	2,127,046	0	9.00
10.00	01000	DIETARY	0	0	0	1,947,777	0	10.00
11.00	01100	CAFETERIA	0	0	0	878,767	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	1,897,808	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	1,506,549	0	14.00
15.00	01500	PHARMACY	0	0	0	2,787,583	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,453,523	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	1,069,583	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	288,949	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	1,768	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	70,708,985	77,392,429	0	19,768,321	0	30.00
31.00	03100	INTENSIVE CARE UNIT	19,833,597	19,833,597	0	3,789,875	0	31.00
31.01	02060	NICU	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	4,524,300	4,524,300	0	1,262,895	0	40.00
43.00	04300	NURSERY	3,596,931	3,596,931	0	1,849,986	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,664,825	17,903,950	0	4,832,167	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,288,397	3,974,852	0	3,195,362	0	52.00
53.00	05300	ANESTHESIOLOGY	1,288,571	2,674,408	0	207,406	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,147,444	30,494,283	0	4,595,073	0	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	25,661,520	47,037,209	0	5,697,877	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	5,245,306	6,325,965	0	1,365,967	0	65.00
66.00	06600	PHYSICAL THERAPY	1,367,206	3,776,829	0	813,033	0	66.00
69.00	06900	ELECTROCARDIOLOGY	2,570,403	5,264,635	0	482,948	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	179,591	225,641	0	168,691	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	165,206	319,984	0	243,313	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,313,328	3,885,779	0	1,403,243	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,579,985	35,572,300	0	2,283,866	0	73.00
75.01	07501	ACUTE DIALYSIS	2,042,700	2,225,850	0	760,310	0	75.01
75.02	03650	CARD CATH LAB	7,153,031	10,590,671	0	919,903	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	11,527	2,813,921	0	4,137,850	0	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0	214,907	0	260,578	0	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	654,942	6,484,098	0	662,753	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	10,618,831	44,932,617	0	5,581,182	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	204,616,626	330,065,156	-14,218,888	84,459,917	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	10,251	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,437,321	0	192.00
192.01	19201	PROHEALTH SERVICES	0	0	0	1,099,230	0	192.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0206

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

Worksheet B-1

Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description			ADMITTING (INPATIENT REVENUE)	CASHIERING (GROSS REVENUE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
			4.03	4.04	5A	5.00	6.00	
192.02	19202	AUXILIARY	0	0	0	642,351	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,700,635	2,476,656		14,218,888	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.008311	0.007504		0.162225	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	122,717	67,866		148,151	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000600	0.000206		0.001690	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0206

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

Worksheet B-1

Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE ((POUNDS OF LAUNDRY))	HOUSEKEEPING (SQUARE FEET)	DIETARY ((MEALS SERVED))	CAFETERIA ((MEALS SERVED))	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
4.01	00401	COMMUNICATIONS					4.01
4.02	00402	DATA PROCESSING					4.02
4.03	00403	ADMITTING					4.03
4.04	00404	CASHIERING					4.04
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT	215,510				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,682	309,685			8.00
9.00	00900	HOUSEKEEPING	3,524	0	208,304		9.00
10.00	01000	DIETARY	7,456	0	7,456	100,260	10.00
11.00	01100	CAFETERIA	3,378	0	3,378	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	47,206	12.00
13.00	01300	NURSING ADMINISTRATION	2,413	0	2,413	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,064	0	11,064	0	14.00
15.00	01500	PHARMACY	4,836	0	4,836	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,978	0	4,978	0	16.00
17.00	01700	SOCIAL SERVICE	153	0	153	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	306	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	120	0	120	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	41,731	99,074	41,731	83,577	30.00
31.00	03100	INTENSIVE CARE UNIT	6,295	13,209	6,295	9,396	31.00
31.01	02060	NICU	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	5,293	0	5,293	7,287	40.00
43.00	04300	NURSERY	3,876	16,535	3,876	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	18,284	56,083	18,284	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,198	47,186	3,198	0	52.00
53.00	05300	ANESTHESIOLOGY	668	0	668	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,778	22,294	9,778	0	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	56.01
60.00	06000	LABORATORY	8,165	0	8,165	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,449	0	2,449	0	65.00
66.00	06600	PHYSICAL THERAPY	2,593	5,730	2,593	0	66.00
69.00	06900	ELECTROCARDIOLOGY	3,177	0	3,177	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	435	0	435	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
75.01	07501	ACUTE DIALYSIS	0	0	0	0	75.01
75.02	03650	CARD CATH LAB	2,133	0	2,133	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	7,902	11,883	7,902	0	90.00
90.01	09001	PH CLINIC	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	1,200	494	1,200	0	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	3,234	1,652	3,234	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	90.05
91.00	09100	EMERGENCY	7,552	35,545	7,552	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	169,567	309,685	162,361	100,260	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	627	0	627	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	45,316	0	45,316	0	192.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0206

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

Worksheet B-1

Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE ((POUNDS OF LAUNDRY))	HOUSEKEEPING (SQUARE FEET)	DIETARY ((MEALS SERVED))	CAFETERIA ((MEALS SERVED))	
			7.00	8.00	9.00	10.00	11.00	
192.01	19201	PROHEALTH SERVICES	0	0	0	0	0	192.01
192.02	19202	AUXILIARY	0	0	0	0	486	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,745,460	596,462	2,582,407	2,589,562	1,168,934	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	31.299986	1.926028	12.397299	25.828466	24.762403	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	987,569	71,827	84,836	165,376	73,402	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.582474	0.231936	0.407270	1.649471	1.554929	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: 14-0206

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

Worksheet B-1

Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description			MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION ((DIRECT NRSG HRS))	CENTRAL SERVICES & SUPPLY ((COSTED REQUIS))	PHARMACY ((COSTED REQUIS))	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
			12.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	ADMITTING						4.03
4.04	00404	CASHIERING						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0					12.00
13.00	01300	NURSING ADMINISTRATION	0	29,996				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,819,819			14.00
15.00	01500	PHARMACY	0	0	0	2,702,724		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	330,065,156	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	14,653	77,843	199,641	77,392,429	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,375	14,719	89,270	19,833,597	31.00
31.01	02060	NICU	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	850	8,914	10,710	4,524,300	40.00
43.00	04300	NURSERY	0	1,534	1,232	4,427	3,596,931	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,586	0	136,619	17,903,950	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,293	14,699	106,811	3,974,852	52.00
53.00	05300	ANESTHESIOLOGY	0	142	9,951	4,692	2,674,408	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	5,556	2,842	30,494,283	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0	0	0	2,076	47,037,209	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,322	0	820	6,325,965	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	3,776,829	66.00
69.00	06900	ELECTROCARDIOLOGY	0	199	105	0	5,264,635	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	225,641	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	239,539	0	319,984	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,354,858	0	3,885,779	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,804,336	35,572,300	73.00
75.01	07501	ACUTE DIALYSIS	0	0	358	10,114	2,225,850	75.01
75.02	03650	CARD CATH LAB	0	411	0	24,212	10,590,671	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	6,315	101,261	2,813,921	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0	0	335	19,528	214,907	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0	0	20,042	30,554	6,484,098	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	3,631	65,087	148,834	44,932,617	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	29,996	1,819,553	2,696,747	330,065,156	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0206

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

Worksheet B-1

Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description			MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION ((DIRECT NRSG HRS))	CENTRAL SERVICES & SUPPLY ((COSTED REQUIS))	PHARMACY ((COSTED REQUIS))	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
			12.00	13.00	14.00	15.00	16.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	266	4,104	0	192.00
192.01	19201	PROHEALTH SERVICES	0	0	0	0	0	192.01
192.02	19202	AUXILIARY	0	0	0	1,873	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	2,344,650	2,262,298	3,506,810	1,931,980	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	78.165422	1.243145	1.297509	0.005853	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	71,488	271,804	180,622	115,150	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	2.383251	0.149358	0.066830	0.000349	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: 14-0206

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

Worksheet B-1

Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description			SOCIAL SERVICE ((TIME SPENT))	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS		
						SERVICES-SALAR Y & FRINGES APPRV ((ASSIGNED TIME))	SERVICES-OTHER PRGM COSTS APPRV ((ASSIGNED TIME))	
						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
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	ADMITTING						4.03
4.04	00404	CASHIERING						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	100					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
20.00	02000	NURSING SCHOOL	0		0			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0			100		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0				100	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0					23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	87	0	0	90	90	30.00
31.00	03100	INTENSIVE CARE UNIT	4	0	0	0	0	31.00
31.01	02060	NICU	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.01	07501	ACUTE DIALYSIS	0	0	0	0	0	75.01
75.02	03650	CARD CATH LAB	0	0	0	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	10	10	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0	0	0	0	0	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0	0	0	0	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	6	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	0	0	100	100	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0206

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

Worksheet B-1

Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description			SOCIAL SERVICE ((TIME SPENT))	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS		
						SERVICES-SALAR Y & FRINGES APPRV ((ASSIGNED TIME))	SERVICES-OTHER PRGM COSTS APPRV ((ASSIGNED TIME))	
						17.00	19.00	
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PROHEALTH SERVICES	0	0	0	0	0	192.01
192.02	19202	AUXILIARY	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,277,021	0	0	343,401	7,299	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12,770.210000	0.000000	0.000000	3,434.010000	72.990000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	7,287	0	0	1,134	2,370	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	72.870000	0.000000	0.000000	11.340000	23.700000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			0			206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			0.000000			207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0206

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

Worksheet B-1

Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description		PARAMED ED PRGM (ASSIGNED TIME)	
		23.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
4.01	00401	COMMUNICATIONS	4.01
4.02	00402	DATA PROCESSING	4.02
4.03	00403	ADMITTING	4.03
4.04	00404	CASHIERING	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
31.01	02060	NICU	31.01
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.01	05601	NUCLEAR MEDICINE	56.01
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
75.01	07501	ACUTE DIALYSIS	75.01
75.02	03650	CARD CATH LAB	75.02
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
90.01	09001	PH CLINIC	90.01
90.02	09002	HEALTHWORKS CLINIC	90.02
90.03	09003	DENTAL CLINIC	90.03
90.04	09004	WOUND CARE THERAPY	90.04
90.05	09005	FAMILY PRACTICE CLINIC	90.05
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	93.99
OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	99.40
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0206

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

Worksheet B-1

Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description			PARAMED ED PRGM (ASSIGNED TIME)	
			23.00	
192.01	19201	PROHEALTH SERVICES	0	192.01
192.02	19202	AUXILIARY	0	192.02
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/26/2020 2:33 pm

			Title XVIII		Hospital		PPS	
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	30,576,372		30,576,372	0	30,576,372	30.00
31.00	03100	INTENSIVE CARE UNIT	5,493,634		5,493,634	0	5,493,634	31.00
31.01	02060	NICU	0		0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	2,026,217		2,026,217	0	2,026,217	40.00
43.00	04300	NURSERY	2,537,539		2,537,539	0	2,537,539	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,109,582		7,109,582	0	7,109,582	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,360,495		4,360,495	0	4,360,495	52.00
53.00	05300	ANESTHESIOLOGY	318,968		318,968	0	318,968	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,066,186		6,066,186	0	6,066,186	54.00
56.01	05601	NUCLEAR MEDICINE	0		0	0	0	56.01
60.00	06000	LABORATORY	7,257,006		7,257,006	0	7,257,006	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,868,737	0	1,868,737	0	1,868,737	65.00
66.00	06600	PHYSICAL THERAPY	1,104,723	0	1,104,723	0	1,104,723	66.00
69.00	06900	ELECTROCARDIOLOGY	751,548		751,548	0	751,548	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	218,095		218,095	0	218,095	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	582,439		582,439	0	582,439	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,337,910		3,337,910	0	3,337,910	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,203,715		5,203,715	0	5,203,715	73.00
75.01	07501	ACUTE DIALYSIS	910,247		910,247	0	910,247	75.01
75.02	03650	CARD CATH LAB	1,298,045		1,298,045	0	1,298,045	75.02
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	5,443,715		5,443,715	167,574	5,611,289	90.00
90.01	09001	PH CLINIC	0		0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	390,728		390,728	0	390,728	90.02
90.03	09003	DENTAL CLINIC	0		0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	1,032,976		1,032,976	0	1,032,976	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0		0	0	0	90.05
91.00	09100	EMERGENCY	7,872,420		7,872,420	0	7,872,420	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,489,795		3,489,795		3,489,795	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0		0		0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0		0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0		0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0		0	99.40
200.00		Subtotal (see instructions)	99,251,092	0	99,251,092	167,574	99,418,666	200.00
201.00		Less Observation Beds	3,489,795		3,489,795		3,489,795	201.00
202.00		Total (see instructions)	95,761,297	0	95,761,297	167,574	95,928,871	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/26/2020 2:33 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	68,051,020		68,051,020			30.00
31.00	03100	INTENSIVE CARE UNIT	19,833,597		19,833,597			31.00
31.01	02060	NICU	0		0			31.01
40.00	04000	SUBPROVIDER - IPF	4,524,300		4,524,300			40.00
43.00	04300	NURSERY	3,596,931		3,596,931			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,664,825	10,239,125	17,903,950	0.397096	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,288,397	686,455	3,974,852	1.097021	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,288,571	1,385,837	2,674,408	0.119267	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,147,444	20,346,839	30,494,283	0.198929	0.000000	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0.000000	0.000000	56.01
60.00	06000	LABORATORY	25,661,520	21,375,689	47,037,209	0.154282	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	5,245,306	1,080,659	6,325,965	0.295407	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,367,206	2,409,623	3,776,829	0.292500	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	2,570,403	2,694,232	5,264,635	0.142754	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	179,591	46,050	225,641	0.966557	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	165,206	154,778	319,984	1.820213	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,313,328	1,572,451	3,885,779	0.859007	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,579,985	9,992,315	35,572,300	0.146286	0.000000	73.00
75.01	07501	ACUTE DIALYSIS	2,042,700	183,150	2,225,850	0.408944	0.000000	75.01
75.02	03650	CARD CATH LAB	7,153,031	3,437,640	10,590,671	0.122565	0.000000	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	11,527	2,802,394	2,813,921	1.934566	0.000000	90.00
90.01	09001	PH CLINIC	0	0	0	0.000000	0.000000	90.01
90.02	09002	HEALTHWORKS CLINIC	0	214,907	214,907	1.818126	0.000000	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	WOUND CARE THERAPY	654,942	5,829,156	6,484,098	0.159309	0.000000	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0.000000	0.000000	90.05
91.00	09100	EMERGENCY	10,618,831	34,313,786	44,932,617	0.175205	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,657,965	6,683,444	9,341,409	0.373583	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000	93.99
	OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
200.00		Subtotal (see instructions)	204,616,626	125,448,530	330,065,156			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	204,616,626	125,448,530	330,065,156			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/26/2020 2:33 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
31.01	02060	NICU			31.01
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.397096		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.097021		52.00
53.00	05300	ANESTHESIOLOGY	0.119267		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.198929		54.00
56.01	05601	NUCLEAR MEDICINE	0.000000		56.01
60.00	06000	LABORATORY	0.154282		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0.295407		65.00
66.00	06600	PHYSICAL THERAPY	0.292500		66.00
69.00	06900	ELECTROCARDIOLOGY	0.142754		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.966557		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.820213		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.859007		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.146286		73.00
75.01	07501	ACUTE DIALYSIS	0.408944		75.01
75.02	03650	CARD CATH LAB	0.122565		75.02
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1.994117		90.00
90.01	09001	PH CLINIC	0.000000		90.01
90.02	09002	HEALTHWORKS CLINIC	1.818126		90.02
90.03	09003	DENTAL CLINIC	0.000000		90.03
90.04	09004	WOUND CARE THERAPY	0.159309		90.04
90.05	09005	FAMILY PRACTICE CLINIC	0.000000		90.05
91.00	09100	EMERGENCY	0.175205		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.373583		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000		93.99
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY			99.40
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/26/2020 2:33 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	30,576,372		30,576,372	0	30,576,372	30.00
31.00	03100	INTENSIVE CARE UNIT	5,493,634		5,493,634	0	5,493,634	31.00
31.01	02060	NICU	0		0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	2,026,217		2,026,217	0	2,026,217	40.00
43.00	04300	NURSERY	2,537,539		2,537,539	0	2,537,539	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,109,582		7,109,582	0	7,109,582	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,360,495		4,360,495	0	4,360,495	52.00
53.00	05300	ANESTHESIOLOGY	318,968		318,968	0	318,968	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,066,186		6,066,186	0	6,066,186	54.00
56.01	05601	NUCLEAR MEDICINE	0		0	0	0	56.01
60.00	06000	LABORATORY	7,257,006		7,257,006	0	7,257,006	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,868,737	0	1,868,737	0	1,868,737	65.00
66.00	06600	PHYSICAL THERAPY	1,104,723	0	1,104,723	0	1,104,723	66.00
69.00	06900	ELECTROCARDIOLOGY	751,548		751,548	0	751,548	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	218,095		218,095	0	218,095	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	582,439		582,439	0	582,439	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,337,910		3,337,910	0	3,337,910	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,203,715		5,203,715	0	5,203,715	73.00
75.01	07501	ACUTE DIALYSIS	910,247		910,247	0	910,247	75.01
75.02	03650	CARD CATH LAB	1,298,045		1,298,045	0	1,298,045	75.02
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	5,443,715		5,443,715	167,574	5,611,289	90.00
90.01	09001	PH CLINIC	0		0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	390,728		390,728	0	390,728	90.02
90.03	09003	DENTAL CLINIC	0		0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	1,032,976		1,032,976	0	1,032,976	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0		0	0	0	90.05
91.00	09100	EMERGENCY	7,872,420		7,872,420	0	7,872,420	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,489,795		3,489,795	0	3,489,795	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0		0		0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0		0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0		0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0		0	99.40
200.00		Subtotal (see instructions)	99,251,092	0	99,251,092	167,574	99,418,666	200.00
201.00		Less Observation Beds	3,489,795		3,489,795		3,489,795	201.00
202.00		Total (see instructions)	95,761,297	0	95,761,297	167,574	95,928,871	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/26/2020 2:33 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		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	68,051,020		68,051,020		30.00
31.00	03100	INTENSIVE CARE UNIT	19,833,597		19,833,597		31.00
31.01	02060	NICU	0		0		31.01
40.00	04000	SUBPROVIDER - IPF	4,524,300		4,524,300		40.00
43.00	04300	NURSERY	3,596,931		3,596,931		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,664,825	10,239,125	17,903,950	0.397096	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,288,397	686,455	3,974,852	1.097021	0.000000
53.00	05300	ANESTHESIOLOGY	1,288,571	1,385,837	2,674,408	0.119267	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,147,444	20,346,839	30,494,283	0.198929	0.000000
56.01	05601	NUCLEAR MEDICINE	0	0	0	0.000000	0.000000
60.00	06000	LABORATORY	25,661,520	21,375,689	47,037,209	0.154282	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000
65.00	06500	RESPIRATORY THERAPY	5,245,306	1,080,659	6,325,965	0.295407	0.000000
66.00	06600	PHYSICAL THERAPY	1,367,206	2,409,623	3,776,829	0.292500	0.000000
69.00	06900	ELECTROCARDIOLOGY	2,570,403	2,694,232	5,264,635	0.142754	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	179,591	46,050	225,641	0.966557	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	165,206	154,778	319,984	1.820213	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,313,328	1,572,451	3,885,779	0.859007	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	25,579,985	9,992,315	35,572,300	0.146286	0.000000
75.01	07501	ACUTE DIALYSIS	2,042,700	183,150	2,225,850	0.408944	0.000000
75.02	03650	CARD CATH LAB	7,153,031	3,437,640	10,590,671	0.122565	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	11,527	2,802,394	2,813,921	1.934566	0.000000
90.01	09001	PH CLINIC	0	0	0	0.000000	0.000000
90.02	09002	HEALTHWORKS CLINIC	0	214,907	214,907	1.818126	0.000000
90.03	09003	DENTAL CLINIC	0	0	0	0.000000	0.000000
90.04	09004	WOUND CARE THERAPY	654,942	5,829,156	6,484,098	0.159309	0.000000
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0.000000	0.000000
91.00	09100	EMERGENCY	10,618,831	34,313,786	44,932,617	0.175205	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,657,965	6,683,444	9,341,409	0.373583	0.000000
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
200.00		Subtotal (see instructions)	204,616,626	125,448,530	330,065,156		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	204,616,626	125,448,530	330,065,156		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/26/2020 2:33 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
31.01	02060	NICU				31.01
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
56.01	05601	NUCLEAR MEDICINE	0.000000			56.01
60.00	06000	LABORATORY	0.000000			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
75.01	07501	ACUTE DIALYSIS	0.000000			75.01
75.02	03650	CARD CATH LAB	0.000000			75.02
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
90.01	09001	PH CLINIC	0.000000			90.01
90.02	09002	HEALTHWORKS CLINIC	0.000000			90.02
90.03	09003	DENTAL CLINIC	0.000000			90.03
90.04	09004	WOUND CARE THERAPY	0.000000			90.04
90.05	09005	FAMILY PRACTICE CLINIC	0.000000			90.05
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part I
Date/Time Prepared:
2/26/2020 2:33 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	1,438,889	0	1,438,889	31,288	45.99	30.00
31.00	INTENSIVE CARE UNIT	222,814		222,814	3,132	71.14	31.00
31.01	NICU	0		0	0	0.00	31.01
40.00	SUBPROVIDER - IPF	135,202	0	135,202	2,429	55.66	40.00
43.00	NURSERY	111,060		111,060	1,196	92.86	43.00
200.00	Total (lines 30 through 199)	1,907,965		1,907,965	38,045		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	6,645	305,604				30.00
31.00	INTENSIVE CARE UNIT	837	59,544				31.00
31.01	NICU	0	0				31.01
40.00	SUBPROVIDER - IPF	737	41,021				40.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	8,219	406,169				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part II
Date/Time Prepared:
2/26/2020 2:33 pm

			Title XVIII		Hospital	PPS		
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	535,518	17,903,950	0.029911	1,956,995	58,536	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	424,017	3,974,852	0.106675	15,592	1,663	52.00
53.00	05300	ANESTHESIOLOGY	37,863	2,674,408	0.014158	345,954	4,898	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	386,895	30,494,283	0.012687	3,343,557	42,420	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0.000000	0	0	56.01
60.00	06000	LABORATORY	273,882	47,037,209	0.005823	7,146,759	41,616	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	80,476	6,325,965	0.012722	1,339,938	17,047	65.00
66.00	06600	PHYSICAL THERAPY	76,170	3,776,829	0.020168	541,252	10,916	66.00
69.00	06900	ELECTROCARDIOLOGY	104,980	5,264,635	0.019941	764,655	15,248	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	16,421	225,641	0.072775	60,260	4,385	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	36,465	319,984	0.113959	36,684	4,180	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	208,276	3,885,779	0.053600	824,591	44,198	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	159,533	35,572,300	0.004485	7,422,259	33,289	73.00
75.01	07501	ACUTE DIALYSIS	4,476	2,225,850	0.002011	920,700	1,852	75.01
75.02	03650	CARD CATH LAB	128,830	10,590,671	0.012164	2,180,419	26,523	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	227,188	2,813,921	0.080737	3,653	295	90.00
90.01	09001	PH CLINIC	0	0	0.000000	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	26,713	214,907	0.124300	0	0	90.02
90.03	09003	DENTAL CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	WOUND CARE THERAPY	82,398	6,484,098	0.012708	188,363	2,394	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0.000000	0	0	90.05
91.00	09100	EMERGENCY	280,366	44,932,617	0.006240	2,528,625	15,779	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	164,226	9,341,409	0.017580	768,886	13,517	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99
200.00		Total (lines 50 through 199)	3,254,693	234,059,308		30,389,142	338,756	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0206		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part III Date/Time Prepared: 2/26/2020 2:33 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		
31.01	02060	NICU	0	0	0	0	0	0	31.01		
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00		
43.00	04300	NURSERY	0	0	0	0	0	0	43.00		
200.00	Total (lines 30 through 199)		0	0	0	0	0	0	200.00		
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)		Inpatient Program Days			
			4.00	5.00	6.00	7.00		8.00			
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	31,288	0.00	6,645		30.00		
31.00	03100	INTENSIVE CARE UNIT		0	3,132	0.00	837		31.00		
31.01	02060	NICU		0	0	0.00	0		31.01		
40.00	04000	SUBPROVIDER - IPF	0	0	2,429	0.00	737		40.00		
43.00	04300	NURSERY		0	1,196	0.00	0		43.00		
200.00	Total (lines 30 through 199)			0	38,045		8,219		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
31.01	02060	NICU	0								31.01
40.00	04000	SUBPROVIDER - IPF	0								40.00
43.00	04300	NURSERY	0								43.00
200.00	Total (lines 30 through 199)		0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0206

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

Worksheet D
Part IV
Date/Time Prepared:
2/26/2020 2:33 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	56.01
60.00	06000	LABORATORY	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
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
75.01	07501	ACUTE DIALYSIS	0	0	0	0	75.01
75.02	03650	CARD CATH LAB	0	0	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	PH CLINIC	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0	0	0	0	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0	0	0	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
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: 14-0206

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

Worksheet D
Part IV
Date/Time Prepared:
2/26/2020 2:33 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	17,903,950	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,974,852	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,674,408	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	30,494,283	0.000000	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0.000000	56.01
60.00	06000	LABORATORY	0	0	0	47,037,209	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,325,965	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,776,829	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,264,635	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	225,641	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	319,984	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,885,779	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	35,572,300	0.000000	73.00
75.01	07501	ACUTE DIALYSIS	0	0	0	2,225,850	0.000000	75.01
75.02	03650	CARD CATH LAB	0	0	0	10,590,671	0.000000	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	2,813,921	0.000000	90.00
90.01	09001	PH CLINIC	0	0	0	0	0.000000	90.01
90.02	09002	HEALTHWORKS CLINIC	0	0	0	214,907	0.000000	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	WOUND CARE THERAPY	0	0	0	6,484,098	0.000000	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	44,932,617	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	9,341,409	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0	234,059,308		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0206

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

Worksheet D
Part IV
Date/Time Prepared:
2/26/2020 2:33 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	1,956,995	0	2,014,326	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	15,592	0	11,140	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	345,954	0	242,238	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	3,343,557	0	2,498,722	0	54.00
56.01	05601	NUCLEAR MEDICINE	0.000000	0	0	0	0	56.01
60.00	06000	LABORATORY	0.000000	7,146,759	0	1,508,763	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	1,339,938	0	131,991	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	541,252	0	14,613	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	764,655	0	499,058	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	60,260	0	8,301	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	36,684	0	150,658	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	824,591	0	278,307	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	7,422,259	0	2,488,705	0	73.00
75.01	07501	ACUTE DIALYSIS	0.000000	920,700	0	34,650	0	75.01
75.02	03650	CARD CATH LAB	0.000000	2,180,419	0	1,760,315	0	75.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	3,653	0	823,305	0	90.00
90.01	09001	PH CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0.000000	0	0	745	0	90.02
90.03	09003	DENTAL CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0.000000	188,363	0	1,964,467	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0.000000	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.000000	2,528,625	0	2,885,960	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	768,886	0	806,036	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Total (lines 50 through 199)		30,389,142	0	18,122,300	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part V
Date/Time Prepared:
2/26/2020 2:33 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	0.397096	2,014,326	0	0	799,881	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.097021	11,140	0	0	12,221	52.00	
53.00	05300	ANESTHESIOLOGY	0.119267	242,238	0	0	28,891	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.198929	2,498,722	0	0	497,068	54.00	
56.01	05601	NUCLEAR MEDICINE	0.000000	0	0	0	0	56.01	
60.00	06000	LABORATORY	0.154282	1,508,763	0	0	232,775	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	0.295407	131,991	0	0	38,991	65.00	
66.00	06600	PHYSICAL THERAPY	0.292500	14,613	0	0	4,274	66.00	
69.00	06900	ELECTROCARDIOLOGY	0.142754	499,058	0	0	71,243	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.966557	8,301	0	0	8,023	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.820213	150,658	0	0	274,230	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.859007	278,307	0	0	239,068	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.146286	2,488,705	0	124	364,063	73.00	
75.01	07501	ACUTE DIALYSIS	0.408944	34,650	0	0	14,170	75.01	
75.02	03650	CARD CATH LAB	0.122565	1,760,315	0	0	215,753	75.02	
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1.934566	823,305	0	0	1,592,738	90.00	
90.01	09001	PH CLINIC	0.000000	0	0	0	0	90.01	
90.02	09002	HEALTHWORKS CLINIC	1.818126	745	0	0	1,355	90.02	
90.03	09003	DENTAL CLINIC	0.000000	0	0	0	0	90.03	
90.04	09004	WOUND CARE THERAPY	0.159309	1,964,467	0	0	312,957	90.04	
90.05	09005	FAMILY PRACTICE CLINIC	0.000000	0	0	0	0	90.05	
91.00	09100	EMERGENCY	0.175205	2,885,960	0	0	505,635	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.373583	806,036	0	0	301,121	92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99	
200.00		Subtotal (see instructions)		18,122,300	0	124	5,514,457	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		18,122,300	0	124	5,514,457	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part V
Date/Time Prepared:
2/26/2020 2:33 pm

			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.01	05601	NUCLEAR MEDICINE	0	0		56.01
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	18		73.00
75.01	07501	ACUTE DIALYSIS	0	0		75.01
75.02	03650	CARD CATH LAB	0	0		75.02
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0		90.00
90.01	09001	PH CLINIC	0	0		90.01
90.02	09002	HEALTHWORKS CLINIC	0	0		90.02
90.03	09003	DENTAL CLINIC	0	0		90.03
90.04	09004	WOUND CARE THERAPY	0	0		90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0		90.05
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
200.00		Subtotal (see instructions)	0	18		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	18		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0206 Component CCN: 14-S206		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part II Date/Time Prepared: 2/26/2020 2:33 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	535,518	17,903,950	0.029911	0	0	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	424,017	3,974,852	0.106675	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	37,863	2,674,408	0.014158	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	386,895	30,494,283	0.012687	21,076	267	54.00	
56.01	05601	NUCLEAR MEDICINE	0	0	0.000000	0	0	56.01	
60.00	06000	LABORATORY	273,882	47,037,209	0.005823	149,496	871	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	80,476	6,325,965	0.012722	75	1	65.00	
66.00	06600	PHYSICAL THERAPY	76,170	3,776,829	0.020168	750	15	66.00	
69.00	06900	ELECTROCARDIOLOGY	104,980	5,264,635	0.019941	14,894	297	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	16,421	225,641	0.072775	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	36,465	319,984	0.113959	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	208,276	3,885,779	0.053600	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	159,533	35,572,300	0.004485	243,415	1,092	73.00	
75.01	07501	ACUTE DIALYSIS	4,476	2,225,850	0.002011	0	0	75.01	
75.02	03650	CARD CATH LAB	128,830	10,590,671	0.012164	0	0	75.02	
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98	
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	227,188	2,813,921	0.080737	0	0	90.00	
90.01	09001	PH CLINIC	0	0	0.000000	0	0	90.01	
90.02	09002	HEALTHWORKS CLINIC	26,713	214,907	0.124300	0	0	90.02	
90.03	09003	DENTAL CLINIC	0	0	0.000000	0	0	90.03	
90.04	09004	WOUND CARE THERAPY	82,398	6,484,098	0.012708	0	0	90.04	
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0.000000	0	0	90.05	
91.00	09100	EMERGENCY	280,366	44,932,617	0.006240	71,231	444	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	9,341,409	0.000000	8,720	0	92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99	
200.00		Total (lines 50 through 199)	3,090,467	234,059,308		509,657	2,987	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0206 Component CCN: 14-S206		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/26/2020 2:33 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
56.01	05601	NUCLEAR MEDICINE		0	0	0	0	0	56.01
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
75.01	07501	ACUTE DIALYSIS		0	0	0	0	0	75.01
75.02	03650	CARD CATH LAB		0	0	0	0	0	75.02
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
90.01	09001	PH CLINIC		0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC		0	0	0	0	0	90.02
90.03	09003	DENTAL CLINIC		0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY		0	0	0	0	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC		0	0	0	0	0	90.05
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		0		0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	0	0	93.99
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0206 Component CCN: 14-S206		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/26/2020 2:33 pm	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	17,903,950	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,974,852	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,674,408	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	30,494,283	0.000000	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0.000000	56.01
60.00	06000	LABORATORY	0	0	0	47,037,209	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,325,965	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,776,829	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,264,635	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	225,641	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	319,984	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,885,779	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	35,572,300	0.000000	73.00
75.01	07501	ACUTE DIALYSIS	0	0	0	2,225,850	0.000000	75.01
75.02	03650	CARD CATH LAB	0	0	0	10,590,671	0.000000	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	2,813,921	0.000000	90.00
90.01	09001	PH CLINIC	0	0	0	0	0.000000	90.01
90.02	09002	HEALTHWORKS CLINIC	0	0	0	214,907	0.000000	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	WOUND CARE THERAPY	0	0	0	6,484,098	0.000000	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	44,932,617	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	9,341,409	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0	234,059,308		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0206 Component CCN: 14-S206		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/26/2020 2:33 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	21,076	0	0	3,084	0	54.00
56.01	05601	NUCLEAR MEDICINE	0.000000	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0.000000	149,496	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	75	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	750	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	14,894	0	0	288	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	243,415	0	0	0	0	73.00
75.01	07501	ACUTE DIALYSIS	0.000000	0	0	0	0	0	75.01
75.02	03650	CARD CATH LAB	0.000000	0	0	0	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00
90.01	09001	PH CLINIC	0.000000	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0.000000	0	0	0	0	0	90.02
90.03	09003	DENTAL CLINIC	0.000000	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0.000000	0	0	0	0	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0.000000	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.000000	71,231	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	8,720	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	0	93.99
200.00		Total (lines 50 through 199)			509,657	0	3,372	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0206

Period:

Worksheet D

Component CCN: 14-S206

From 10/01/2018
To 09/30/2019Part V
Date/Time Prepared:
2/26/2020 2:33 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
		1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.397096	0	0	0	0 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.097021	0	0	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.119267	0	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.198929	3,084	0	0	613 54.00
56.01	05601 NUCLEAR MEDICINE	0.000000	0	0	0	0 56.01
60.00	06000 LABORATORY	0.154282	0	0	0	0 60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0 62.30
65.00	06500 RESPIRATORY THERAPY	0.295407	0	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.292500	0	0	0	0 66.00
69.00	06900 ELECTROCARDIOLOGY	0.142754	288	0	0	41 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.966557	0	0	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.820213	0	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.859007	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.146286	0	0	0	0 73.00
75.01	07501 ACUTE DIALYSIS	0.408944	0	0	0	0 75.01
75.02	03650 CARD CATH LAB	0.122565	0	0	0	0 75.02
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0 76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0 76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	1.934566	0	0	0	0 90.00
90.01	09001 PH CLINIC	0.000000	0	0	0	0 90.01
90.02	09002 HEALTHWORKS CLINIC	1.818126	0	0	0	0 90.02
90.03	09003 DENTAL CLINIC	0.000000	0	0	0	0 90.03
90.04	09004 WOUND CARE THERAPY	0.159309	0	0	0	0 90.04
90.05	09005 FAMILY PRACTICE CLINIC	0.000000	0	0	0	0 90.05
91.00	09100 EMERGENCY	0.175205	0	0	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.373583	0	0	0	0 92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0 93.99
200.00	Subtotal (see instructions)		3,372	0	0	654 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 - line 201)		3,372	0	0	654 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0206

Period:

Worksheet D

Component CCN: 14-S206

From 10/01/2018
To 09/30/2019Part V
Date/Time Prepared:
2/26/2020 2:33 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description			Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	56.01
60.00	06000	LABORATORY	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
75.01	07501	ACUTE DIALYSIS	0	0	75.01
75.02	03650	CARD CATH LAB	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	09001	PH CLINIC	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0	0	90.02
90.03	09003	DENTAL CLINIC	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	90.05
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part I
Date/Time Prepared:
2/26/2020 2:33 pm

			Title XIX		Hospital	Cost	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,438,889	0	1,438,889	31,288	45.99	30.00
31.00	INTENSIVE CARE UNIT	222,814		222,814	3,132	71.14	31.00
31.01	NICU	0		0	0	0.00	31.01
40.00	SUBPROVIDER - IPF	135,202	0	135,202	2,429	55.66	40.00
43.00	NURSERY	111,060		111,060	1,196	92.86	43.00
200.00	Total (lines 30 through 199)	1,907,965		1,907,965	38,045		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,408	156,734				
31.00	INTENSIVE CARE UNIT	396	28,171				
31.01	NICU	0	0				
40.00	SUBPROVIDER - IPF	975	54,269				
43.00	NURSERY	450	41,787				
200.00	Total (lines 30 through 199)	5,229	280,961				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part II
Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description			Title XIX		Hospital	Cost		
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	535,518	17,903,950	0.029911	736,881	22,041	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	424,017	3,974,852	0.106675	231,964	24,745	52.00
53.00	05300	ANESTHESIOLOGY	37,863	2,674,408	0.014158	108,504	1,536	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	386,895	30,494,283	0.012687	997,138	12,651	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0.000000	0	0	56.01
60.00	06000	LABORATORY	273,882	47,037,209	0.005823	2,573,965	14,988	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	80,476	6,325,965	0.012722	532,811	6,778	65.00
66.00	06600	PHYSICAL THERAPY	76,170	3,776,829	0.020168	113,914	2,297	66.00
69.00	06900	ELECTROCARDIOLOGY	104,980	5,264,635	0.019941	203,715	4,062	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	16,421	225,641	0.072775	20,960	1,525	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	36,465	319,984	0.113959	5,923	675	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	208,276	3,885,779	0.053600	151,282	8,109	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	159,533	35,572,300	0.004485	2,229,818	10,001	73.00
75.01	07501	ACUTE DIALYSIS	4,476	2,225,850	0.002011	103,950	209	75.01
75.02	03650	CARD CATH LAB	128,830	10,590,671	0.012164	434,427	5,284	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	227,188	2,813,921	0.080737	0	0	90.00
90.01	09001	PH CLINIC	0	0	0.000000	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	26,713	214,907	0.124300	0	0	90.02
90.03	09003	DENTAL CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	WOUND CARE THERAPY	82,398	6,484,098	0.012708	34,969	444	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0.000000	0	0	90.05
91.00	09100	EMERGENCY	280,366	44,932,617	0.006240	1,090,653	6,806	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	164,226	9,341,409	0.017580	187,807	3,302	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99
200.00		Total (lines 50 through 199)	3,254,693	234,059,308		9,758,681	125,453	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0206		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part III Date/Time Prepared: 2/26/2020 2:33 pm		
					Title XIX		Hospital		Cost		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost				
			1A	1.00	2A	2.00	3.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00		
31.01	02060	NICU	0	0	0	0	0	0	31.01		
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00		
43.00	04300	NURSERY	0	0	0	0	0	0	43.00		
200.00	Total (lines 30 through 199)		0	0	0	0	0	0	200.00		
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)		Inpatient Program Days			
			4.00	5.00	6.00	7.00		8.00			
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	31,288	0.00	3,408		30.00		
31.00	03100	INTENSIVE CARE UNIT		0	3,132	0.00	396		31.00		
31.01	02060	NICU		0	0	0.00	0		31.01		
40.00	04000	SUBPROVIDER - IPF	0	0	2,429	0.00	975		40.00		
43.00	04300	NURSERY		0	1,196	0.00	450		43.00		
200.00	Total (lines 30 through 199)			0	38,045		5,229		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
31.01	02060	NICU	0								31.01
40.00	04000	SUBPROVIDER - IPF	0								40.00
43.00	04300	NURSERY	0								43.00
200.00	Total (lines 30 through 199)		0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0206		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/26/2020 2:33 pm	
			Title XIX		Hospital		Cost	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.01	07501	ACUTE DIALYSIS	0	0	0	0	0	75.01
75.02	03650	CARD CATH LAB	0	0	0	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0	0	0	0	0	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0	0	0	0	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description			Title XIX		Hospital	Cost		
			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	17,903,950	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,974,852	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,674,408	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	30,494,283	0.000000	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0.000000	56.01
60.00	06000	LABORATORY	0	0	0	47,037,209	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,325,965	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,776,829	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,264,635	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	225,641	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	319,984	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,885,779	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	35,572,300	0.000000	73.00
75.01	07501	ACUTE DIALYSIS	0	0	0	2,225,850	0.000000	75.01
75.02	03650	CARD CATH LAB	0	0	0	10,590,671	0.000000	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	2,813,921	0.000000	90.00
90.01	09001	PH CLINIC	0	0	0	0	0.000000	90.01
90.02	09002	HEALTHWORKS CLINIC	0	0	0	214,907	0.000000	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	WOUND CARE THERAPY	0	0	0	6,484,098	0.000000	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	44,932,617	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	9,341,409	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0	234,059,308		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0206		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/26/2020 2:33 pm	
Cost Center Description				Title XIX		Hospital		Cost	
				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000		736,881	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		231,964	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000		108,504	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		997,138	0	0	0	54.00
56.01	05601	NUCLEAR MEDICINE	0.000000		0	0	0	0	56.01
60.00	06000	LABORATORY	0.000000		2,573,965	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000		532,811	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000		113,914	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		203,715	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		20,960	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		5,923	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		151,282	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		2,229,818	0	0	0	73.00
75.01	07501	ACUTE DIALYSIS	0.000000		103,950	0	0	0	75.01
75.02	03650	CARD CATH LAB	0.000000		434,427	0	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0.000000		0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000		0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000		0	0	0	0	90.00
90.01	09001	PH CLINIC	0.000000		0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0.000000		0	0	0	0	90.02
90.03	09003	DENTAL CLINIC	0.000000		0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0.000000		34,969	0	0	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0.000000		0	0	0	0	90.05
91.00	09100	EMERGENCY	0.000000		1,090,653	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		187,807	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000		0	0	0	0	93.99
200.00		Total (lines 50 through 199)			9,758,681	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0206

Period:

Worksheet D

Component CCN: 14-S206

From 10/01/2018
To 09/30/2019Part II
Date/Time Prepared:
2/26/2020 2:33 pm

				Title XIX		Subprovider - IPF		Cost	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
			1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	535,518	17,903,950	0.029911	0	0	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	424,017	3,974,852	0.106675	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	37,863	2,674,408	0.014158	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	386,895	30,494,283	0.012687	0	0	54.00	
56.01	05601	NUCLEAR MEDICINE	0	0	0.000000	0	0	56.01	
60.00	06000	LABORATORY	273,882	47,037,209	0.005823	0	0	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	80,476	6,325,965	0.012722	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	76,170	3,776,829	0.020168	0	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	104,980	5,264,635	0.019941	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	16,421	225,641	0.072775	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	36,465	319,984	0.113959	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	208,276	3,885,779	0.053600	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	159,533	35,572,300	0.004485	0	0	73.00	
75.01	07501	ACUTE DIALYSIS	4,476	2,225,850	0.002011	0	0	75.01	
75.02	03650	CARD CATH LAB	128,830	10,590,671	0.012164	0	0	75.02	
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98	
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	227,188	2,813,921	0.080737	0	0	90.00	
90.01	09001	PH CLINIC	0	0	0.000000	0	0	90.01	
90.02	09002	HEALTHWORKS CLINIC	26,713	214,907	0.124300	0	0	90.02	
90.03	09003	DENTAL CLINIC	0	0	0.000000	0	0	90.03	
90.04	09004	WOUND CARE THERAPY	82,398	6,484,098	0.012708	0	0	90.04	
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0.000000	0	0	90.05	
91.00	09100	EMERGENCY	280,366	44,932,617	0.006240	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	9,341,409	0.000000	0	0	92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99	
200.00		Total (lines 50 through 199)	3,090,467	234,059,308		0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0206
Component CCN: 14-S206

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

Worksheet D
Part IV
Date/Time Prepared:
2/26/2020 2:33 pm

			Title XIX		Subprovider - IPF		Cost	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.01	07501	ACUTE DIALYSIS	0	0	0	0	0	75.01
75.02	03650	CARD CATH LAB	0	0	0	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0	0	0	0	0	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0	0	0	0	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0206 Component CCN: 14-S206		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/26/2020 2:33 pm	
			Title XIX		Subprovider - IPF		Cost	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	17,903,950	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,974,852	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,674,408	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	30,494,283	0.000000	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0.000000	56.01
60.00	06000	LABORATORY	0	0	0	47,037,209	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,325,965	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,776,829	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,264,635	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	225,641	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	319,984	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,885,779	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	35,572,300	0.000000	73.00
75.01	07501	ACUTE DIALYSIS	0	0	0	2,225,850	0.000000	75.01
75.02	03650	CARD CATH LAB	0	0	0	10,590,671	0.000000	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	2,813,921	0.000000	90.00
90.01	09001	PH CLINIC	0	0	0	0	0.000000	90.01
90.02	09002	HEALTHWORKS CLINIC	0	0	0	214,907	0.000000	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	WOUND CARE THERAPY	0	0	0	6,484,098	0.000000	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	44,932,617	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	9,341,409	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0	234,059,308		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0206 Component CCN: 14-S206		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/26/2020 2:33 pm	
				Title XIX		Subprovider - IPF		Cost	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	0	54.00
56.01	05601	NUCLEAR MEDICINE	0.000000	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0.000000	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	0	73.00
75.01	07501	ACUTE DIALYSIS	0.000000	0	0	0	0	0	75.01
75.02	03650	CARD CATH LAB	0.000000	0	0	0	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00
90.01	09001	PH CLINIC	0.000000	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0.000000	0	0	0	0	0	90.02
90.03	09003	DENTAL CLINIC	0.000000	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0.000000	0	0	0	0	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0.000000	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.000000	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	0	93.99
200.00		Total (lines 50 through 199)			0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0206	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/26/2020 2:33 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)		31,288	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		31,288	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)		27,717	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		6,645	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		30,576,372	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)		30,576,372	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)		30,576,372	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)		977.26	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		6,493,893	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)		6,493,893	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0206

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

Worksheet D-1

Date/Time Prepared:
2/26/2020 2:33 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		42.00
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT	5,493,634	3,132	1,754.03	837	1,468,123		43.00
43.01	NICU	0	0	0.00	0	0		43.01
44.00	CORONARY CARE UNIT							44.00
45.00	BURN INTENSIVE CARE UNIT							45.00
46.00	SURGICAL INTENSIVE CARE UNIT							46.00
47.00	OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					6,596,970		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					14,558,986		49.00
PASS THROUGH COST ADJUSTMENTS								
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					365,148		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					338,756		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					703,904		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					13,855,082		53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges					0		54.00
55.00	Target amount per discharge					0.00		55.00
56.00	Target amount (line 54 x line 55)					0		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00	Bonus payment (see instructions)					0		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00	Relief payment (see instructions)					0		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)					3,571		87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					977.26		88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,489,795		89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0206

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

Worksheet D-1

Date/Time Prepared:
2/26/2020 2:33 pm

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	1,438,889	30,576,372	0.047059	3,489,795	164,226	90.00
91.00 Nursing School cost	0	30,576,372	0.000000	3,489,795	0	91.00
92.00 Allied health cost	0	30,576,372	0.000000	3,489,795	0	92.00
93.00 All other Medical Education	0	30,576,372	0.000000	3,489,795	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0206 Component CCN: 14-S206	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/26/2020 2:33 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,429	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,429	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,429	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		737	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,026,217	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,026,217	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,026,217	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)		834.18	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		614,791	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)		614,791	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0206	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1
			Component CCN: 14-S206		Date/Time Prepared: 2/26/2020 2:33 pm
			Title XVIII	Subprovider - IPF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0
43.01 NICU	0	0	0.00	0	0
44.00 CORONARY CARE UNIT					
45.00 BURN INTENSIVE CARE UNIT					
46.00 SURGICAL INTENSIVE CARE UNIT					
47.00 OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					80,971
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					695,762
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					41,021
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,987
52.00 Total Program excludable cost (sum of lines 50 and 51)					44,008
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					651,754
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)					0
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0206 Component CCN: 14-S206		Period: From 10/01/2018 To 09/30/2019		Worksheet D-1 Date/Time Prepared: 2/26/2020 2:33 pm
			Title XVIII		Subprovider - IPF		PPS
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	135,202	2,026,217	0.066726	0	0	90.00
91.00	Nursing School cost	0	2,026,217	0.000000	0	0	91.00
92.00	Allied health cost	0	2,026,217	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,026,217	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0206	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/26/2020 2:33 pm
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			31,288 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			31,288 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)			27,717 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			3,408 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			1,196 15.00
16.00	Nursery days (title V or XIX only)			450 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)			30,576,372 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)			30,576,372 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)			30,576,372 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)			977.26 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			3,330,502 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			3,330,502 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0206

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

Worksheet D-1

Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description		Title XIX			Hospital	Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	2,537,539	1,196	2,121.69	450	954,761	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	5,493,634	3,132	1,754.03	396	694,596	43.00
43.01	NICU	0	0	0.00	0	0	43.01
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,225,055	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					7,204,914	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					3,571	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					977.26	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,489,795	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0206

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

Worksheet D-1

Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description		Title XIX		Hospital		Cost	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,438,889	30,576,372	0.047059	3,489,795	164,226	90.00
91.00	Nursing School cost	0	30,576,372	0.000000	3,489,795	0	91.00
92.00	Allied health cost	0	30,576,372	0.000000	3,489,795	0	92.00
93.00	All other Medical Education	0	30,576,372	0.000000	3,489,795	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0206	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/26/2020 2:33 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		16,634,485		30.00
31.00	03100	INTENSIVE CARE UNIT		5,164,019		31.00
31.01	02060	NICU		0		31.01
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.397096	1,956,995	777,115	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.097021	15,592	17,105	52.00
53.00	05300	ANESTHESIOLOGY	0.119267	345,954	41,261	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.198929	3,343,557	665,130	54.00
56.01	05601	NUCLEAR MEDICINE	0.000000	0	0	56.01
60.00	06000	LABORATORY	0.154282	7,146,759	1,102,616	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.295407	1,339,938	395,827	65.00
66.00	06600	PHYSICAL THERAPY	0.292500	541,252	158,316	66.00
69.00	06900	ELECTROCARDIOLOGY	0.142754	764,655	109,158	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.966557	60,260	58,245	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.820213	36,684	66,773	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.859007	824,591	708,329	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.146286	7,422,259	1,085,773	73.00
75.01	07501	ACUTE DIALYSIS	0.408944	920,700	376,515	75.01
75.02	03650	CARD CATH LAB	0.122565	2,180,419	267,243	75.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.994117	3,653	7,285	90.00
90.01	09001	PH CLINIC	0.000000	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	1.818126	0	0	90.02
90.03	09003	DENTAL CLINIC	0.000000	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0.159309	188,363	30,008	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0.000000	0	0	90.05
91.00	09100	EMERGENCY	0.175205	2,528,625	443,028	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.373583	768,886	287,243	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
200.00		Total (sum of lines 50 through 94 and 96 through 98)		30,389,142	6,596,970	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)		30,389,142		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0206 Component CCN: 14-S206	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/26/2020 2:33 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
31.01	02060 NICU		0		31.01
40.00	04000 SUBPROVIDER - IPF		1,346,770		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.397096	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.097021	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.119267	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.198929	21,076	4,193	54.00
56.01	05601 NUCLEAR MEDICINE	0.000000	0	0	56.01
60.00	06000 LABORATORY	0.154282	149,496	23,065	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.295407	75	22	65.00
66.00	06600 PHYSICAL THERAPY	0.292500	750	219	66.00
69.00	06900 ELECTROCARDIOLOGY	0.142754	14,894	2,126	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.966557	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.820213	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.859007	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.146286	243,415	35,608	73.00
75.01	07501 ACUTE DIALYSIS	0.408944	0	0	75.01
75.02	03650 CARD CATH LAB	0.122565	0	0	75.02
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	1.994117	0	0	90.00
90.01	09001 PH CLINIC	0.000000	0	0	90.01
90.02	09002 HEALTHWORKS CLINIC	1.818126	0	0	90.02
90.03	09003 DENTAL CLINIC	0.000000	0	0	90.03
90.04	09004 WOUND CARE THERAPY	0.159309	0	0	90.04
90.05	09005 FAMILY PRACTICE CLINIC	0.000000	0	0	90.05
91.00	09100 EMERGENCY	0.175205	71,231	12,480	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.373583	8,720	3,258	92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
200.00	Total (sum of lines 50 through 94 and 96 through 98)		509,657	80,971	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)		509,657		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0206	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/26/2020 2:33 pm	
Cost Center Description			Title XIX	Hospital	Cost	
			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		6,270,924		30.00
31.00	03100	INTENSIVE CARE UNIT		2,457,424		31.00
31.01	02060	NICU		0		31.01
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY		952,661		43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.397096	736,881	292,612	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.097021	231,964	254,469	52.00
53.00	05300	ANESTHESIOLOGY	0.119267	108,504	12,941	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.198929	997,138	198,360	54.00
56.01	05601	NUCLEAR MEDICINE	0.000000	0	0	56.01
60.00	06000	LABORATORY	0.154282	2,573,965	397,116	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.295407	532,811	157,396	65.00
66.00	06600	PHYSICAL THERAPY	0.292500	113,914	33,320	66.00
69.00	06900	ELECTROCARDIOLOGY	0.142754	203,715	29,081	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.966557	20,960	20,259	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.820213	5,923	10,781	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.859007	151,282	129,952	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.146286	2,229,818	326,191	73.00
75.01	07501	ACUTE DIALYSIS	0.408944	103,950	42,510	75.01
75.02	03650	CARD CATH LAB	0.122565	434,427	53,246	75.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.934566	0	0	90.00
90.01	09001	PH CLINIC	0.000000	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	1.818126	0	0	90.02
90.03	09003	DENTAL CLINIC	0.000000	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0.159309	34,969	5,571	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0.000000	0	0	90.05
91.00	09100	EMERGENCY	0.175205	1,090,653	191,088	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.373583	187,807	70,162	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
200.00		Total (sum of lines 50 through 94 and 96 through 98)		9,758,681	2,225,055	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)		9,758,681		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet E
Part A
Date/Time Prepared:
2/26/2020 2:33 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)			10,190,710	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)			497,331	2.04
3.00	Managed Care Simulated Payments			3,985,596	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			163.17	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)			2.68	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.			1.74	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)			12.44	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)			13.38	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			12.56	10.00
11.00	FTE count for residents in dental and podiatric programs.			3.00	11.00
12.00	Current year allowable FTE (see instructions)			15.56	12.00
13.00	Total allowable FTE count for the prior year.			10.26	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.			4.26	14.00
15.00	Sum of lines 12 through 14 divided by 3.			10.03	15.00
16.00	Adjustment for residents in initial years of the program			0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00	17.00
18.00	Adjusted rolling average FTE count			10.03	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.061470	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.061456	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.061456	21.00
22.00	IME payment adjustment (see instructions)			336,355	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			131,549	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)			-0.82	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)			336,355	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			131,549	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			26.89	30.00
31.00	Percentage of Medicaid patient days (see instructions)			56.91	31.00
32.00	Sum of lines 30 and 31			83.80	32.00
33.00	Allowable disproportionate share percentage (see instructions)			58.35	33.00
34.00	Disproportionate share adjustment (see instructions)			1,486,570	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0206	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part A Date/Time Prepared: 2/26/2020 2:33 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	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	2,729,476	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	2,729,476	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		2,729,476		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)	15,240,442			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0			48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			15,371,991	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			1,028,494	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).			237,123	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)			16,637,608	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			16,637,608	61.00
62.00	Deductibles billed to program beneficiaries			1,003,100	62.00
63.00	Coinsurance billed to program beneficiaries			133,718	63.00
64.00	Allowable bad debts (see instructions)			806,965	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			524,527	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			542,898	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			16,025,317	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)			-9,614	70.93
70.94	HRR adjustment amount (see instructions)			-57,068	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet E
Part A
Date/Time Prepared:
2/26/2020 2:33 pm

		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	0	70.97
70.98	Low Volume Payment-3		0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		15,958,635		71.00
71.01	Sequestration adjustment (see instructions)		319,173		71.01
71.02	Demonstration payment adjustment amount after sequestration		0		71.02
72.00	Interim payments		15,240,781		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)		398,681		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		294,767		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	0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	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	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	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: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
2/26/2020 2:33 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	0
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	10,190,710	0	0	10,190,710	10,190,710
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	497,331	0	0
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	497,331	0	0	0	0
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	3,985,596	0	0	3,985,596	3,985,596
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.061456	0.061456	0.061456	0.061456	0.061456
6.00	IME payment adjustment (see instructions)	22.00	336,355	0	0	336,355	336,355
6.01	IME payment adjustment for managed care (see instructions)	22.01	131,549	0	0	131,549	131,549
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	0.000000
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	336,355	0	0	336,355	336,355
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	131,549	0	0	131,549	131,549
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.5835	0.5835	0.5835	0.5835	0.5835
11.00	Disproportionate share adjustment (see instructions)	34.00	1,486,570	0	0	1,486,570	1,486,570
11.01	Uncompensated care payments	36.00	2,729,476	0	0	2,729,476	2,729,476
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	15,240,442	0	497,331	14,743,111	15,240,442
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	15,371,991	0	497,331	14,874,660	15,371,991
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,028,494	0	0	1,028,494	1,028,494

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
2/26/2020 2:33 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	497,331	15,903,154	16,400,485
		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	829,059	0	0	829,059	829,059
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	17,954	0	0	17,954	17,954
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	0.0340	0.0340	0.0340	0.0340	
23.00	Indirect medical education adjustment (see instructions)	6.00	28,188	0	0	28,188	28,188
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1849	0.1849	0.1849	0.1849	
25.00	Disproportionate share adjustment (see instructions)	11.00	153,293	0	0	153,293	153,293
26.00	Total prospective capital payments (see instructions)	12.00	1,028,494	0	0	1,028,494	1,028,494
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.000000	0.000000	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
2/26/2020 2:33 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	10,190,710		10,190,710	10,190,710	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	497,331		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	497,331		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	3,985,596	0	3,985,596	3,985,596	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.061456	0.061456	0.061456		5.00
6.00	IME payment adjustment (see instructions)	22.00	336,355	0	336,355	336,355	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	131,549	0	131,549	131,549	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	336,355	0	336,355	336,355	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	131,549	0	131,549	131,549	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.5835	0.5835	0.5835		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	1,486,570	0	1,486,570	1,486,570	11.00
11.01	Uncompensated care payments	36.00	2,729,476	0	2,729,476	2,729,476	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	15,240,442	497,331	14,743,111	15,240,442	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	15,371,991	497,331	14,874,660	15,371,991	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,028,494	0	1,028,494	1,028,494	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			497,331	15,903,154	16,400,485	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
2/26/2020 2:33 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	829,059	0	829,059	829,059	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	17,954	0	17,954	17,954	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	0.0340	0.0340	0.0340		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	28,188	0	28,188	28,188	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1849	0.1849	0.1849		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	153,293	0	153,293	153,293	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,028,494	0	1,028,494	1,028,494	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-9,614	0	-9,614	-9,614	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	-57,068	0	-57,068	-57,068	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	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0206	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part B Date/Time Prepared: 2/26/2020 2:33 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		18	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		5,514,457	2.00
3.00	OPPS payments		3,496,623	3.00
4.00	Outlier payment (see instructions)		11,758	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)		18	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		124	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)		124	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)		124	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		106	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)		18	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)		3,508,381	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)		708,267	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)		2,800,132	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		85,727	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)		2,885,859	30.00
31.00	Primary payer payments		55	31.00
32.00	Subtotal (line 30 minus line 31)		2,885,804	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)		311,235	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		202,303	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		188,197	36.00
37.00	Subtotal (see instructions)		3,088,107	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,088,107	40.00
40.01	Sequestration adjustment (see instructions)		61,762	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		3,123,334	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-96,989	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0206	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part B Date/Time Prepared: 2/26/2020 2:33 pm
		Component CCN: 14-S206		
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		654	2.00
3.00	OPPS payments		582	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		582	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)		116	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)		466	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)		466	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		466	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		466	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		466	40.00
40.01	Sequestration adjustment (see instructions)		9	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		457	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		0	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: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet E-1
Part I
Date/Time Prepared:
2/26/2020 2:33 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		15,063,060		3,087,145	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	09/11/2019	177,721	09/11/2019	36,189	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)		177,721		36,189	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)		15,240,781		3,123,334	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		398,681		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		96,989	6.02
7.00	Total Medicare program liability (see instructions)		15,639,462		3,026,345	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: 14-0206

Period:

Worksheet E-1

Component CCN: 14-S206

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/26/2020 2:33 pm

Title XVIII

Subprovider -
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		616,200		457	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)		616,200		457	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		22,214		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		638,414		457	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0206	Period: From 10/01/2018 To 09/30/2019	Worksheet E-1 Part II Date/Time Prepared: 2/26/2020 2:33 pm	
		Title XVIII	Hospital	PPS	
				1.00	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14				1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20				6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168				7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)				10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)				32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet E-3
Part I
Date/Time Prepared:
2/26/2020 2:33 pm

		Title XVIII	Hospital	2/20/2020 2:33 pm	
				PPS	
				1.00	
PART I - MEDICARE PART A SERVICES - TEFRA					
1.00	Inpatient hospital services (see instructions)			0	1.00
1.01	Nursing and allied health managed care payment (see instructions)			0	1.01
2.00	Organ acquisition			0	2.00
3.00	Cost of physicians' services in a teaching hospital (see instructions)			0	3.00
4.00	Subtotal (sum of lines 1 through 3)			0	4.00
5.00	Primary payer payments			0	5.00
6.00	Subtotal (line 4 less line 5).			0	6.00
7.00	Deductibles			0	7.00
8.00	Subtotal (line 6 minus line 7)			0	8.00
9.00	Coinsurance			0	9.00
10.00	Subtotal (line 8 minus line 9)			0	10.00
11.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0	11.00
12.00	Adjusted reimbursable bad debts (see instructions)			0	12.00
13.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	13.00
14.00	Subtotal (sum of lines 10 and 12)			0	14.00
15.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0	15.00
16.00	DO NOT USE THIS LINE				16.00
17.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	17.00
17.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	17.50
17.99	Demonstration payment adjustment amount before sequestration			0	17.99
18.00	Total amount payable to the provider (see instructions)			0	18.00
18.01	Sequestration adjustment (see instructions)			0	18.01
18.02	Demonstration payment adjustment amount after sequestration			0	18.02
19.00	Interim payments			0	19.00
20.00	Tentative settlement (for contractor use only)			0	20.00
21.00	Balance due provider/program (line 18 minus lines 18.01, 18.02, 19, and 20)			0	21.00
22.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0	22.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0206 Component CCN: 14-S206	Period: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part II Date/Time Prepared: 2/26/2020 2:33 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			712,966 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			6.654795 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			712,966 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			712,966 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			712,966 18.00
19.00	Deductibles			55,612 19.00
20.00	Subtotal (line 18 minus line 19)			657,354 20.00
21.00	Coinurance			28,578 21.00
22.00	Subtotal (line 20 minus line 21)			628,776 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			34,873 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			22,667 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			1,025 25.00
26.00	Subtotal (sum of lines 22 and 24)			651,443 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			651,443 31.00
31.01	Sequestration adjustment (see instructions)			13,029 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			616,200 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			22,214 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet E-3
Part VII
Date/Time Prepared:
2/26/2020 2:33 pm

		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		7,204,914		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		7,204,914	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		7,204,914	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		9,681,009		8.00
9.00	Ancillary service charges		9,758,681	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		19,439,690	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		19,439,690	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		12,234,776	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		7,204,914	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0	0	24.00
25.00	Capital exception payments (see instructions)		0	0	25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		7,204,914	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		7,204,914	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		7,204,914	0	36.00
37.00	INTERIM PAYMENT RECONCILIATION		-5,043,414	0	37.00
38.00	Subtotal (line 36 ± line 37)		2,161,500	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		2,161,500	0	40.00
41.00	Interim payments		2,161,500	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0206 Component CCN: 14-S206	Period: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part VII Date/Time Prepared: 2/26/2020 2:33 pm	
		Title XIX	Subprovider - IPF	Cost	
			Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0		41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0206		Period: From 10/01/2018 To 09/30/2019		Worksheet E-4 Date/Time Prepared: 2/26/2020 2:33 pm	
		Title XVIII		Hospital		PPS	
						1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT							
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.					1.98	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)					0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA					0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)					1.29	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))					0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)					0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)					12.44	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)					13.13	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)					12.56	6.00
7.00	Enter the lesser of line 5 or line 6					12.56	7.00
		Primary Care	Other	Total			
		1.00	2.00	3.00			
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	12.56	0.00	12.56		8.00	
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	12.56	0.00	12.56		9.00	
10.00	Weighted dental and podiatric resident FTE count for the current year		3.00			10.00	
10.01	Unweighted dental and podiatric resident FTE count for the current year		3.00			10.01	
11.00	Total weighted FTE count	12.56	3.00	15.56		11.00	
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	7.26	3.00	10.26		12.00	
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	1.26	3.00	4.26		13.00	
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	7.03	3.00	10.03		14.00	
15.00	Adjustment for residents in initial years of new programs	0.00	0.00	0.00		15.00	
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00	0.00		15.01	
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00	0.00		16.00	
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00	0.00		16.01	
17.00	Adjusted rolling average FTE count	7.03	3.00	10.03		17.00	
18.00	Per resident amount	98,736.92	98,736.92	197,473.84		18.00	
19.00	Approved amount for resident costs	694,121	296,211	990,332		19.00	
				1.00			
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00		20.00	
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00		21.00	
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00		22.00	
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00		23.00	
24.00	Multiply line 22 time line 23			0		24.00	
25.00	Total direct GME amount (sum of lines 19 and 24)			990,332		25.00	
		Inpatient Part	Managed care				
		A					
		1.00	2.00	3.00			
COMPUTATION OF PROGRAM PATIENT LOAD							
26.00	Inpatient Days (see instructions)	8,219	3,111			26.00	
27.00	Total Inpatient Days (see instructions)	33,406	33,406			27.00	
28.00	Ratio of inpatient days to total inpatient days	0.246034	0.093127			28.00	
29.00	Program direct GME amount	243,655	92,227			29.00	
30.00	Reduction for direct GME payments for Medicare Advantage		13,032			30.00	
31.00	Net Program direct GME amount			322,850		31.00	

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0206	Period: From 10/01/2018 To 09/30/2019	Worksheet E-4 Date/Time Prepared: 2/26/2020 2:33 pm	
		Title XVIII	Hospital	PPS	
			1.00		
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0		32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		0		33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000		34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0		35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0		36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)		15,254,748		37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0		38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0		39.00
40.00	Primary payer payments (see instructions)		0		40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		15,254,748		41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)		5,515,129		42.00
43.00	Primary payer payments (see instructions)		55		43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		5,515,074		44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		20,769,822		45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.734467		46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.265533		47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)		322,850		48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		237,123		49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		85,727		50.00

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

Provider CCN: 14-0206

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

Worksheet G

Date/Time Prepared:
2/26/2020 2:33 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	17,781,284	0	0	0	1.00
2.00 Temporary investments	17,290,678	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	33,902,370	0	0	0	4.00
5.00 Other receivable	4,296,034	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-19,293,069	0	0	0	6.00
7.00 Inventory	1,501,371	0	0	0	7.00
8.00 Prepaid expenses	1,068,111	0	0	0	8.00
9.00 Other current assets	2,416,875	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)	58,963,654	0	0	0	11.00
FIXED ASSETS					
12.00 Land	4,840,913	0	0	0	12.00
13.00 Land improvements	3,689,647	0	0	0	13.00
14.00 Accumulated depreciation	-3,279,602	0	0	0	14.00
15.00 Buildings	53,590,150	0	0	0	15.00
16.00 Accumulated depreciation	-39,791,197	0	0	0	16.00
17.00 Leasehold improvements	0	0	0	0	17.00
18.00 Accumulated depreciation	0	0	0	0	18.00
19.00 Fixed equipment	29,405,775	0	0	0	19.00
20.00 Accumulated depreciation	-19,904,918	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	58,226,267	0	0	0	23.00
24.00 Accumulated depreciation	-50,826,871	0	0	0	24.00
25.00 Minor equipment depreciable	0	0	0	0	25.00
26.00 Accumulated depreciation	0	0	0	0	26.00
27.00 HIT designated Assets	0	0	0	0	27.00
28.00 Accumulated depreciation	0	0	0	0	28.00
29.00 Minor equipment-nondepreciable	0	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	35,950,164	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	4,580,852	0	0	0	31.00
32.00 Deposits on leases	0	0	0	0	32.00
33.00 Due from owners/officers	0	0	0	0	33.00
34.00 Other assets	7,554,299	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	12,135,151	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	107,048,969	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	8,376,403	0	0	0	37.00
38.00 Salaries, wages, and fees payable	2,198,946	0	0	0	38.00
39.00 Payroll taxes payable	609,931	0	0	0	39.00
40.00 Notes and loans payable (short term)	0	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	0	0	0	0	43.00
44.00 Other current liabilities	10,669,008	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	21,854,288	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	26,563,030	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	15,767,674	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	42,330,704	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	64,184,992	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	42,863,977	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	42,863,977	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	107,048,969	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0206

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

Worksheet G-1

Date/Time Prepared:
2/26/2020 2:33 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		50,058,644		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-7,194,667				2.00
3.00	Total (sum of line 1 and line 2)		42,863,977		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		42,863,977		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		42,863,977		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0206

Period:
From 10/01/2018
To 09/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
2/26/2020 2:33 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	71,042,284		71,042,284	1.00
2.00	SUBPROVIDER - IPF	4,524,300		4,524,300	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)	75,566,584		75,566,584	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	19,895,129		19,895,129	11.00
11.01	NICU	0		0	11.01
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)	19,895,129		19,895,129	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	95,461,713		95,461,713	17.00
18.00	Ancillary services	108,911,770	0	108,911,770	18.00
19.00	Outpatient services	0	140,092,841	140,092,841	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	204,373,483	140,092,841	344,466,324	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		118,874,068		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)		118,874,068		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0206

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

Worksheet G-3

Date/Time Prepared:
2/26/2020 2:33 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	344,466,324	1.00
2.00	Less contractual allowances and discounts on patients' accounts	276,544,090	2.00
3.00	Net patient revenues (line 1 minus line 2)	67,922,234	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	118,874,068	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-50,951,834	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	938,174	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	334,429	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	330	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	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MEDICAID HOSP ASSESSMENT RMB	35,797,656	24.00
24.01	ACA ACCESS REV	2,194,177	24.01
24.02	MOB RENT	429,502	24.02
24.03	EHR RECEIPTS	26,771	24.03
24.04	SOR GRANT	576,334	24.04
24.05	MEDICAL EDUCATION	1,963,296	24.05
24.06	OTHER	1,496,498	24.06
24.07	OTHER (SPECIFY)	0	24.07
24.08	OTHER (SPECIFY)	0	24.08
24.09	OTHER (SPECIFY)	0	24.09
24.10	OTHER (SPECIFY)	0	24.10
25.00	Total other income (sum of lines 6-24)	43,757,167	25.00
26.00	Total (line 5 plus line 25)	-7,194,667	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-7,194,667	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0206	Period: From 10/01/2018 To 09/30/2019	Worksheet L Parts I-III Date/Time Prepared: 2/26/2020 2:33 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		829,059	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		17,954	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		84.87	3.00
4.00	Number of interns & residents (see instructions)		10.03	4.00
5.00	Indirect medical education percentage (see instructions)		3.40	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)		28,188	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		26.89	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		56.91	8.00
9.00	Sum of lines 7 and 8		83.80	9.00
10.00	Allowable disproportionate share percentage (see instructions)		18.49	10.00
11.00	Disproportionate share adjustment (see instructions)		153,293	11.00
12.00	Total prospective capital payments (see instructions)		1,028,494	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