

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: 14-0224	Period: From 07/01/2018 To 06/30/2019	Worksheet S Parts I-III Date/Time Prepared: 12/5/2019 9:25 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date:	Time:
	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 PRESENCE SAINT JOSEPH HOSP-CHICAGO (14-0224) for the cost reporting period beginning 07/01/2018 and ending 06/30/2019 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)

CHIEF FINANCIAL OFFICER
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	468,491	292,437	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	12,459	4		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	9,215	-644		0	7.00
200.00	Total	0	490,165	291,797	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: 14-0224		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 12/5/2019 9:25 am		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 2900 NORTH LAKE SHORE DRIVE			PO Box:				1.00		
2.00	City: CHICAGO			State: IL		Zip Code: 60657		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			PRESENCE SAINT JOSEPH HOSP-CHICAGO	140224	16974	1	07/01/1966	N P O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF			REHAB UNIT	14T224	16974	5	07/01/1985	N P O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF			SKILLED CARE	145568	16974		01/28/1987	N P N	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
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)						07/01/2018	06/30/2019		20.00
21.00	Type of Control (see instructions)						1			21.00
							1.00	2.00		
							2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		23.00	
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
				1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	3,506	0	526	4,829	321	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0224

Period:
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		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	17	0	0	27		25.00
						Urban/Rural St	Date of Geogra	
						1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
						Beginning:	Ending:	
						1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
						Y/N	Y/N	
						1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
						V	XVIII	XIX
						1.00	2.00	3.00
Prospective Payment System (PPS)-Capital								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	Y	N
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals								
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					Y		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
				1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)					Y		60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)						23.00	1

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00		2.00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)				Y		63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
64.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		8.12	29.85	0.213853		64.00

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
65.01			0.00	0.00	0.000000	65.01
			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 Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	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)		9.23	33.94	0.213806	66.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			1.00	2.00	3.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	FAMILY MEDICINE	1350	0.97	17.01	0.053949
67.01			0.00	0.00	0.000000	67.01
				1.00	2.00	3.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				Y	75.00

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			1.00	2.00	3.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N		0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N			80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N			81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N			85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N			87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00

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		Physical 1.00	Occupational 2.00	Speech 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.	N	N	N	N		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
						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
						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.	1					118.00
		Premiums		Losses		Insurance	
		1.00		2.00		3.00	
118.01	List amounts of malpractice premiums and paid losses:	0		0		5,429,376	
						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.	Y				5.06	122.00
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N					125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.						134.00
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y				14H082	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0224		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 12/5/2019 9:25 am	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: PRESENCE CARE TRANSFORMATION CORP		Contractor's Name: NGS		Contractor's Number: 00131		141.00		
142.00	Street: 200 S. WACKER DRIVE		PO Box:				142.00		
143.00	City: CHICAGO		State: IL		Zip Code: 60606		143.00		
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					Y		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					N		146.00	
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital			N	N	N	N		155.00
156.00	Subprovider - IPF			N	N	N	N		156.00
157.00	Subprovider - IRF			N	N	N	N		157.00
158.00	SUBPROVIDER								158.00
159.00	SNF			N	N	N	N		159.00
160.00	HOME HEALTH AGENCY			N	N	N	N		160.00
161.00	CMHC				N	N	N		161.00
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
				Name	County	State	Zip Code	CBSA	FTE/Campus
				0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00
								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)					07/01/2018	06/30/2019	170.00	
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N		0	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0224	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 12/5/2019 9:25 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		Y	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	11/21/2019	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0224	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 12/5/2019 9:25 am
		Description	Y/N	Y/N
		0	1.00	3.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N
		Y/N	Date	Y/N
		1.00	2.00	3.00
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		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			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.		N	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.		N	35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N	40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICK	GILLILAND	41.00
42.00	Enter the employer/company name of the cost report preparer	PRESENCE HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	847-813-3718	PATRICK.GILLILAND@AMITAHEALTH.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part II
Date/Time Prepared:
12/5/2019 9:25 am

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REGIONAL DIRECTOR OF REIMBURSEMENT	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

Health Financial Systems		PRESENCE SAINT JOSEPH HOSP-CHICAGO		Non-CMS HFS Worksheet	
HFS Supplemental Information		Provider CCN: 14-0224	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part IX Date/Time Prepared: 12/5/2019 9:25 am	
			Title V 1.00	Title XIX 2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE					
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)	Y	Y		1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.01)	Y	Y		2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.02)	Y	Y		3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?	N	N		3.01
			Inpatient 1.00	Outpatient 2.00	
CRITICAL ACCESS HOSPITALS					
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N		4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N		5.00
			Title V 1.00	Title XIX 2.00	
RCE DISALLOWANCE					
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.05)	Y	Y		6.00
PASS THROUGH COST					
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.06)	Y	Y		7.00
RHC					
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N		8.00
FQHC					
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N		9.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
12/5/2019 9:25 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	224	79,259	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)		224	79,259	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	19	6,935	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		243	86,194	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	34	12,410		0	16.00
17.00 SUBPROVIDER - IRF	41.00	10	3,650		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	26	9,490		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		313			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		1	365			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: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
12/5/2019 9:25 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	10,688	528	33,424			1.00
2.00	HMO and other (see instructions)	3,588	7,165				2.00
3.00	HMO IPF Subprovider	0	1,255				3.00
4.00	HMO IRF Subprovider	44	39				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	10,688	528	33,424			7.00
8.00	INTENSIVE CARE UNIT	1,339	25	2,357			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		1,114	2,737			13.00
14.00	Total (see instructions)	12,027	1,667	38,518	118.27	890.56	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	0	235	5,111	0.00	41.21	16.00
17.00	SUBPROVIDER - IRF	219	5	384	0.00	3.87	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	4,308	35	6,633	0.00	29.45	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)			133			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				118.27	965.09	27.00
28.00	Observation Bed Days		385	2,909			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	350	686			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			32			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: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
12/5/2019 9:25 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,475	451	9,079	1.00
2.00 HMO and other (see instructions)			755	1,091		2.00
3.00 HMO IPF Subprovider				284		3.00
4.00 HMO IRF Subprovider				3		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	2,475	451	9,079	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	0	44	906	16.00
17.00 SUBPROVIDER - IRF	0.00	0	26	1	42	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part II
Date/Time Prepared:
12/5/2019 9:25 am

		Wkst. A Line Number	Amount Reported	Reclassification 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	66,833,776	356,811	67,190,587	2,007,397.13	33.47	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		391,825	0	391,825	2,060.00	190.21	4.00
4.01	Physicians - Part A - Teaching		538,489	0	538,489	7,475.80	72.03	4.01
5.00	Physician and Non Physician-Part B		81,802	0	81,802	514.00	159.15	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	8,114,531	8,114,531	287,324.00	28.24	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	1,965,978	0	1,965,978	61,249.00	32.10	9.00
10.00	Excluded area salaries (see instructions)		6,026,430	8,294	6,034,724	92,883.00	64.97	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		3,446,574	0	3,446,574	92,467.59	37.27	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		16,789,570	0	16,789,570	385,996.00	43.50	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		15,189,039	0	15,189,039			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,513,883	0	1,513,883			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		43,605	0	43,605			22.00
22.01	Physician Part A - Teaching		93,922	0	93,922			22.01
23.00	Physician Part B		9,718	0	9,718			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		1,733,516	0	1,733,516			25.00
25.50	Home office wage-related (core)		824,878	0	824,878			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	-311,716	356,811	45,095	0.00	0.00	26.00
27.00	Administrative & General	5.00	6,840,990	0	6,840,990	185,551.00	36.87	27.00
28.00	Administrative & General under contract (see inst.)		649,525	0	649,525	2,981.00	217.89	28.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part II
Date/Time Prepared:
12/5/2019 9:25 am

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
29.00	Maintenance & Repairs	6.00	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	131,606	0	131,606	9,026.00	31.00
32.00	Housekeeping	9.00	818,238	0	818,238	52,858.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,592,245	-819,153	773,092	45,112.05	34.00
35.00	Dietary under contract (see instructions)		643,396	0	643,396	14,560.00	35.00
36.00	Cafeteria	11.00	0	819,153	819,153	59,193.26	36.00
37.00	Maintenance of Personnel	12.00	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,257,818	0	1,257,818	25,992.00	38.00
39.00	Central Services and Supply	14.00	193,705	0	193,705	10,344.00	39.00
40.00	Pharmacy	15.00	1,918,460	-8,294	1,910,166	49,947.38	40.00
41.00	Medical Records & Medical Records Library	16.00	79,935	0	79,935	2,752.00	41.00
42.00	Social Service	17.00	30,545	0	30,545	1,406.00	42.00
43.00	Other General Service	18.00	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part III
Date/Time Prepared:
12/5/2019 9:25 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	67,506,406	-7,757,720	59,748,686	1,729,624.33	34.54	1.00
2.00	Excluded area salaries (see instructions)	7,992,408	8,294	8,000,702	154,132.00	51.91	2.00
3.00	Subtotal salaries (line 1 minus line 2)	59,513,998	-7,766,014	51,747,984	1,575,492.33	32.85	3.00
4.00	Subtotal other wages & related costs (see inst.)	20,236,144	0	20,236,144	478,463.59	42.29	4.00
5.00	Subtotal wage-related costs (see inst.)	16,057,522	0	16,057,522	0.00	31.03	5.00
6.00	Total (sum of lines 3 thru 5)	95,807,664	-7,766,014	88,041,650	2,053,955.92	42.86	6.00
7.00	Total overhead cost (see instructions)	13,844,747	348,517	14,193,264	459,722.69	30.87	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part IV
Date/Time Prepared:
12/5/2019 9:25 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	2,497,220	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)	3,232,723	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	6,233,818	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	166,400	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	35,981	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)	208,300	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	1,087,286	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	4,892,039	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	94,439	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	135,477	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	18,583,683	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COST	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0224

 Period:
 From 07/01/2018
 To 06/30/2019

 Worksheet S-3
 Part V
 Date/Time Prepared:
 12/5/2019 9:25 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	3,446,574	18,583,683	1.00
2.00	Hospital	3,446,574	15,189,039	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	77,871	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	590,192	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	2,726,581	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019

Worksheet S-7

Date/Time Prepared:
12/5/2019 9:25 am

		1.00	2.00	3.00	4.00
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N			2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	1	0	1 3.00
4.00		RUL	39	0	39 4.00
5.00		RVX	6	0	6 5.00
6.00		RVL	18	0	18 6.00
7.00		RHX	0	0	0 7.00
8.00		RHL	0	0	0 8.00
9.00		RMX	0	0	0 9.00
10.00		RML	0	0	0 10.00
11.00		RLX	0	0	0 11.00
12.00		RUC	297	0	297 12.00
13.00		RUB	1,121	0	1,121 13.00
14.00		RUA	1,962	0	1,962 14.00
15.00		RVC	43	0	43 15.00
16.00		RVB	191	0	191 16.00
17.00		RVA	247	0	247 17.00
18.00		RHC	5	0	5 18.00
19.00		RHB	20	0	20 19.00
20.00		RHA	50	0	50 20.00
21.00		RMC	5	0	5 21.00
22.00		RMB	34	0	34 22.00
23.00		RMA	30	0	30 23.00
24.00		RLB	0	0	0 24.00
25.00		RLA	0	0	0 25.00
26.00		ES3	0	0	0 26.00
27.00		ES2	0	0	0 27.00
28.00		ES1	3	0	3 28.00
29.00		HE2	0	0	0 29.00
30.00		HE1	0	0	0 30.00
31.00		HD2	0	0	0 31.00
32.00		HD1	0	0	0 32.00
33.00		HC2	0	0	0 33.00
34.00		HC1	2	0	2 34.00
35.00		HB2	0	0	0 35.00
36.00		HB1	4	0	4 36.00
37.00		LE2	0	0	0 37.00
38.00		LE1	0	0	0 38.00
39.00		LD2	0	0	0 39.00
40.00		LD1	5	0	5 40.00
41.00		LC2	0	0	0 41.00
42.00		LC1	0	0	0 42.00
43.00		LB2	0	0	0 43.00
44.00		LB1	21	0	21 44.00
45.00		CE2	0	0	0 45.00
46.00		CE1	5	0	5 46.00
47.00		CD2	0	0	0 47.00
48.00		CD1	29	0	29 48.00
49.00		CC2	0	0	0 49.00
50.00		CC1	22	0	22 50.00
51.00		CB2	0	0	0 51.00
52.00		CB1	45	0	45 52.00
53.00		CA2	0	0	0 53.00
54.00		CA1	76	0	76 54.00
55.00		SE3	0	0	0 55.00
56.00		SE2	0	0	0 56.00
57.00		SE1	0	0	0 57.00
58.00		SSC	0	0	0 58.00
59.00		SSB	0	0	0 59.00
60.00		SSA	0	0	0 60.00
61.00		IB2	0	0	0 61.00
62.00		IB1	0	0	0 62.00
63.00		IA2	0	0	0 63.00
64.00		IA1	0	0	0 64.00
65.00		BB2	0	0	0 65.00
66.00		BB1	0	0	0 66.00
67.00		BA2	0	0	0 67.00
68.00		BA1	0	0	0 68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019

Worksheet S-7

Date/Time Prepared:
12/5/2019 9:25 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	3	0	3	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	4	0	4	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	13	0	13	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	6	0	6	78.00
199.00		AAA	1	0	1	199.00
200.00	TOTAL		4,308	0	4,308	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
SNF SERVICES						
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).			16974	16974	201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		0	0.00		202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		7,508,060			207.00

Health Financial Systems		PRESENCE SAINT JOSEPH HOSP-CHICAGO		In Lieu of Form CMS-2552-10	
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0224	Period: From 07/01/2018 To 06/30/2019	Worksheet S-10 Date/Time Prepared: 12/5/2019 9:25 am	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.199970	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			14,915,486	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			115,517,512	6.00
7.00	Medicaid cost (line 1 times line 6)			23,100,037	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)			8,184,551	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)			8,184,551	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	8,048,645	3,143,979	11,192,624	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,609,488	3,143,979	4,753,467	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,609,488	3,143,979	4,753,467	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			2,376,417	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			892,628	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			1,373,273	27.01
28.00	Non-Medicare bad debt expense (see instructions)			1,003,144	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			681,244	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			5,434,711	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			13,619,262	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019

Worksheet A

Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		5,881,531	5,881,531	-104,785	5,776,746	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	6,798,909	6,798,909	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-311,716	872,011	560,295	0	560,295	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	131,645	131,645	5.01
5.02	00550	DATA PROCESSING	0	0	0	0	0	5.02
5.03	00560	PURCHASING, RECEIVING&STORES	0	107	107	-498,120	-498,013	5.03
5.04	00570	ADMITTING	0	0	0	0	0	5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	0	0	0	0	0	5.05
5.06	00591	ADMINISTRATION & GENERAL	6,840,990	73,976,848	80,817,838	-3,429,544	77,388,294	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	50	50	0	50	6.00
7.00	00700	OPERATION OF PLANT	0	2,512,335	2,512,335	-63	2,512,272	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	131,606	584,070	715,676	-4,758	710,918	8.00
9.00	00900	HOUSEKEEPING	818,238	2,600,530	3,418,768	-22,765	3,396,003	9.00
10.00	01000	DIETARY	1,592,245	2,458,974	4,051,219	-2,230,407	1,820,812	10.00
11.00	01100	CAFETERIA	0	0	0	2,165,901	2,165,901	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,257,818	450,710	1,708,528	-55,650	1,652,878	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	193,705	1,248,700	1,442,405	-76,341	1,366,064	14.00
15.00	01500	PHARMACY	1,918,460	4,780,920	6,699,380	-4,057,451	2,641,929	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	79,935	267,423	347,358	-40,316	307,042	16.00
17.00	01700	SOCIAL SERVICE	30,545	195,527	226,072	0	226,072	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	9,850,520	9,850,520	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	11,612,934	5,063,531	16,676,465	-10,796,558	5,879,907	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	190,212	25,837	216,049	-12,468	203,581	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,500,389	6,745,924	20,246,313	-678,566	19,567,747	30.00
31.00	03100	INTENSIVE CARE UNIT	1,859,027	745,165	2,604,192	-221,587	2,382,605	31.00
40.00	04000	SUBPROVIDER - IPF	2,659,497	925,175	3,584,672	-11,478	3,573,194	40.00
41.00	04100	SUBPROVIDER - IRF	284,546	82,676	367,222	-1,485	365,737	41.00
43.00	04300	NURSERY	1,665,430	448,138	2,113,568	738,972	2,852,540	43.00
44.00	04400	SKILLED NURSING FACILITY	1,965,978	629,483	2,595,461	-43,006	2,552,455	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,334,876	15,967,341	21,302,217	-7,620,919	13,681,298	50.00
51.00	05100	RECOVERY ROOM	543,417	125,038	668,455	-7,676	660,779	51.00
53.00	05300	ANESTHESIOLOGY	102,402	842,823	945,225	-601,717	343,508	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,313,384	1,794,520	4,107,904	-479,008	3,628,896	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,092,650	872,436	1,965,086	-76,292	1,888,794	55.00
57.00	05700	CT SCAN	365,886	176,733	542,619	-27,287	515,332	57.00
58.00	05800	MRI	300,840	402,214	703,054	-327,938	375,116	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,114,097	2,003,420	3,117,517	-1,000,026	2,117,491	59.00
60.00	06000	LABORATORY	0	6,608,409	6,608,409	-111,411	6,496,998	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	419,938	419,938	18,656	438,594	63.00
65.00	06500	RESPIRATORY THERAPY	958,250	568,292	1,526,542	-71,510	1,455,032	65.00
66.00	06600	PHYSICAL THERAPY	2,036,784	375,041	2,411,825	-16,474	2,395,351	66.00
69.00	06900	ELECTROCARDIOLOGY	358,087	312,350	670,437	-39,483	630,954	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	52,416	14,367	66,783	-936	65,847	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,368,080	4,368,080	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,808,955	3,808,955	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,848,070	5,848,070	73.00
74.00	07400	RENAL DIALYSIS	0	322,787	322,787	-127	322,660	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	86,742	22,917	109,659	-3,720	105,939	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	493,641	170,356	663,997	-50,555	613,442	90.00
91.00	09100	EMERGENCY	2,185,961	1,447,938	3,633,899	-251,154	3,382,745	91.00
91.01	09101	PARTIAL HOSPITALIZATION	312,329	76,482	388,811	-12,376	376,435	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	63,941,601	143,019,067	206,960,668	745,751	207,706,419	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	2,892,175	2,137,865	5,030,040	-745,751	4,284,289	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	66,833,776	145,156,932	211,990,708	0	211,990,708	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019

Worksheet A

Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,961,816	7,738,562	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	8,739,375	15,538,284	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	390,657	950,952	4.00
5.01	00540	NONPATIENT TELEPHONES	0	131,645	5.01
5.02	00550	DATA PROCESSING	5,455,442	5,455,442	5.02
5.03	00560	PURCHASING, RECEIVING&STORES	119,863	-378,150	5.03
5.04	00570	ADMITTING	0	0	5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	1,848,823	1,848,823	5.05
5.06	00591	ADMINISTRATION & GENERAL	-28,565,041	48,823,253	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	50	6.00
7.00	00700	OPERATION OF PLANT	97,199	2,609,471	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,753	713,671	8.00
9.00	00900	HOUSEKEEPING	0	3,396,003	9.00
10.00	01000	DIETARY	-15	1,820,797	10.00
11.00	01100	CAFETERIA	-1,013,816	1,152,085	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	-5,000	1,647,878	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,366,064	14.00
15.00	01500	PHARMACY	-16,454	2,625,475	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	773,706	1,080,748	16.00
17.00	01700	SOCIAL SERVICE	0	226,072	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	9,850,520	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	-314,149	5,565,758	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	203,581	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,904,051	17,663,696	30.00
31.00	03100	INTENSIVE CARE UNIT	478,913	2,861,518	31.00
40.00	04000	SUBPROVIDER - IPF	0	3,573,194	40.00
41.00	04100	SUBPROVIDER - IRF	0	365,737	41.00
43.00	04300	NURSERY	-11,964	2,840,576	43.00
44.00	04400	SKILLED NURSING FACILITY	-2,004	2,550,451	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-960,269	12,721,029	50.00
51.00	05100	RECOVERY ROOM	0	660,779	51.00
53.00	05300	ANESTHESIOLOGY	-350,370	-6,862	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-167,314	3,461,582	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-226,323	1,662,471	55.00
57.00	05700	CT SCAN	0	515,332	57.00
58.00	05800	MRI	0	375,116	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,117,491	59.00
60.00	06000	LABORATORY	31,955	6,528,953	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	438,594	63.00
65.00	06500	RESPIRATORY THERAPY	0	1,455,032	65.00
66.00	06600	PHYSICAL THERAPY	-8,175	2,387,176	66.00
69.00	06900	ELECTROCARDIOLOGY	-195,925	435,029	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	65,847	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,368,080	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,808,955	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,848,070	73.00
74.00	07400	RENAL DIALYSIS	0	322,660	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	105,939	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	-2,535	610,907	90.00
91.00	09100	EMERGENCY	-320,538	3,062,207	91.00
91.01	09101	PARTIAL HOSPITALIZATION	-24,071	352,364	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-14,187,512	193,518,907	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07950	OTHER	-1,450,792	2,833,497	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-15,638,304	196,352,404	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet Non-CMS Wo
Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.01	NONPATIENT TELEPHONES	00540	NONPATIENT TELEPHONES	5.01
5.02	DATA PROCESSING	00550	DATA PROCESSING	5.02
5.03	PURCHASING, RECEIVING&STORES	00560	PURCHASING RECEIVING AND STORES	5.03
5.04	ADMITTING	00570	ADMITTING	5.04
5.05	CASHIERING/ACCTS RECEIVABLE	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.05
5.06	ADMINISTRATION & GENERAL	00591		5.06
6.00	MAINTENANCE & REPAIRS	00600		6.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
12.00	MAINTENANCE OF PERSONNEL	01200		12.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
19.00	NONPHYSICIAN ANESTHETISTS	01900		19.00
20.00	NURSING SCHOOL	02000		20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRV	02100		21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	02200		22.00
23.00	PARAMED ED PRGM-(SPECIFY)	02300		23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
40.00	SUBPROVIDER - IPF	04000		40.00
41.00	SUBPROVIDER - IRF	04100		41.00
43.00	NURSERY	04300		43.00
44.00	SKILLED NURSING FACILITY	04400		44.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
55.00	RADIOLOGY-THERAPEUTIC	05500		55.00
57.00	CT SCAN	05700		57.00
58.00	MRI	05800		58.00
59.00	CARDIAC CATHETERIZATION	05900		59.00
60.00	LABORATORY	06000		60.00
62.30	BLOOD CLOTTING FOR HEMOPHILIACS	06250		62.30
63.00	BLOOD STORING, PROCESSING & TRANS.	06300		63.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
69.00	ELECTROCARDIOLOGY	06900		69.00
70.00	ELECTROENCEPHALOGRAPHY	07000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
74.00	RENAL DIALYSIS	07400		74.00
76.00	OTHER ANCILLARY SERVICE COST CENTER	03950		76.00
76.97	CARDIAC REHABILITATION	07697		76.97
76.98	HYPERBARIC OXYGEN THERAPY	07698		76.98
76.99	LITHOTRIPSY	07699		76.99
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
91.01	PARTIAL HOSPITALIZATION	09101		91.01
92.00	OBSERVATION BEDS (NON-DISTINCT PART	09200		92.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
NONREIMBURSABLE COST CENTERS				
194.00	OTHER	07950		194.00
194.01	LAKESHORE GUEST UNIT	07951		194.01
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

RECLASSIFICATIONS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet A-6
Date/Time Prepared:
12/5/2019 9:25 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	5,848,070		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
	TOTALS		0	5,848,070		
	B - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	3,808,955		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
	TOTALS		0	3,808,955		
	C - CHARGABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	4,368,080		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

RECLASSIFICATIONS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-6

Date/Time Prepared:
12/5/2019 9:25 am

Increases					
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
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
TOTALS					
D - NURSEY					
1.00	43.00	602,029	205,657		1.00
NURSERY					
TOTALS					
E - CAFETERIA					
1.00	11.00	819,153	1,346,748		1.00
CAFETERIA					
TOTALS					
F - PHYSICIAN DEPR CHAIRMAN					
1.00	30.00	847,086	90,085		1.00
ADULTS & PEDIATRICS					
TOTALS					
G - SALARY EARNED TIME OFF ACCRUAL					
1.00	4.00	356,811	0		1.00
EMPLOYEE BENEFITS DEPARTMENT					
TOTALS					
H - EQUIP DEPRECIATION					
1.00	2.00	0	6,798,909		1.00
CAP REL COSTS-MVBLE EQUIP					
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
TOTALS					
I - PHONES					
1.00	5.01	0	131,645		1.00
NONPATIENT TELEPHONES					
TOTALS					
J - PHARMACY RESIDENCY COSTS					
1.00	23.00	8,294	4,572		1.00
PARAMED ED PRGM-(SPECIFY)					
TOTALS					
L - INTERNS AND RESIDENTS SALARY					
1.00	21.00	8,114,531	1,735,989		1.00
I&R SERVICES-SALARY & FRINGES					
APPRV					
TOTALS					
M - BLOOD RECLASS					
1.00	63.00	0	18,656		1.00
BLOOD STORING, PROCESSING & TRANS.					
TOTALS					
500.00	Grand Total: Increases		10,747,904	24,357,366	500.00

RECLASSIFICATIONS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-6

Date/Time Prepared:
12/5/2019 9:25 am

	Decreases				Wkst. A-7 Ref.			
	Cost Center	Line #	Salary	Other				
	6.00	7.00	8.00	9.00				10.00
	A - DRUGS							
1.00	ADMINISTRATION & GENERAL	5.06	0	135	0	1.00		
2.00	OPERATION OF PLANT	7.00	0	8	0	2.00		
3.00	PHARMACY	15.00	0	4,040,947	0	3.00		
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	34,670	0	4.00		
5.00	ADULTS & PEDIATRICS	30.00	0	282,522	0	5.00		
6.00	INTENSIVE CARE UNIT	31.00	0	39,785	0	6.00		
7.00	SUBPROVIDER - IRF	41.00	0	68	0	7.00		
8.00	NURSERY	43.00	0	17,257	0	8.00		
9.00	SKILLED NURSING FACILITY	44.00	0	12,172	0	9.00		
10.00	OPERATING ROOM	50.00	0	188,046	0	10.00		
11.00	RECOVERY ROOM	51.00	0	5,043	0	11.00		
12.00	ANESTHESIOLOGY	53.00	0	218,984	0	12.00		
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	15,382	0	13.00		
14.00	RADIOLOGY-THERAPEUTIC	55.00	0	42,600	0	14.00		
15.00	CT SCAN	57.00	0	23,169	0	15.00		
16.00	MRI	58.00	0	24,890	0	16.00		
17.00	CARDIAC CATHETERIZATION	59.00	0	77,112	0	17.00		
18.00	LABORATORY	60.00	0	3,361	0	18.00		
19.00	RESPIRATORY THERAPY	65.00	0	6,235	0	19.00		
20.00	PHYSICAL THERAPY	66.00	0	2,409	0	20.00		
21.00	ELECTROCARDIOLOGY	69.00	0	6,728	0	21.00		
22.00	ELECTROENCEPHALOGRAPHY	70.00	0	5	0	22.00		
23.00	CLINIC	90.00	0	6,324	0	23.00		
24.00	EMERGENCY	91.00	0	100,925	0	24.00		
25.00	OTHER	194.00	0	699,038	0	25.00		
26.00	SUBPROVIDER - IPF	40.00	0	255	0	26.00		
	TOTALS		0	5,848,070				
	B - IMPLANTS							
1.00	PHARMACY	15.00	0	319	0	1.00		
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,608	0	2.00		
3.00	ADULTS & PEDIATRICS	30.00	0	39,483	0	3.00		
4.00	INTENSIVE CARE UNIT	31.00	0	14,759	0	4.00		
5.00	NURSERY	43.00	0	2,370	0	5.00		
6.00	SKILLED NURSING FACILITY	44.00	0	1,061	0	6.00		
7.00	OPERATING ROOM	50.00	0	3,151,151	0	7.00		
8.00	RECOVERY ROOM	51.00	0	60	0	8.00		
9.00	ANESTHESIOLOGY	53.00	0	14,137	0	9.00		
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,539	0	10.00		
11.00	CT SCAN	57.00	0	4,085	0	11.00		
12.00	MRI	58.00	0	367	0	12.00		
13.00	CARDIAC CATHETERIZATION	59.00	0	513,250	0	13.00		
14.00	RESPIRATORY THERAPY	65.00	0	56	0	14.00		
15.00	PHYSICAL THERAPY	66.00	0	370	0	15.00		
16.00	ELECTROCARDIOLOGY	69.00	0	34	0	16.00		
17.00	CLINIC	90.00	0	36,163	0	17.00		
18.00	EMERGENCY	91.00	0	27,117	0	18.00		
19.00	OTHER	194.00	0	8	0	19.00		
20.00	SUBPROVIDER - IPF	40.00	0	18	0	20.00		
	TOTALS		0	3,808,955				
	C - CHARGABLE SUPPLIES							
1.00	PURCHASING, RECEIVING&STORES	5.03	0	57	0	1.00		
2.00	ADMINISTRATION & GENERAL	5.06	0	24	0	2.00		
3.00	OPERATION OF PLANT	7.00	0	55	0	3.00		
4.00	HOUSEKEEPING	9.00	0	2,028	0	4.00		
5.00	DIETARY	10.00	0	39	0	5.00		
6.00	NURSING ADMINISTRATION	13.00	0	35	0	6.00		
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	3,300	0	7.00		
8.00	PHARMACY	15.00	0	3,319	0	8.00		
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	3,038	0	9.00		
10.00	I&R SERVICES-OTHER PRGM COSTS	22.00	0	8,867	0	10.00		
	APPRV							
11.00	ADULTS & PEDIATRICS	30.00	0	389,774	0	11.00		
12.00	INTENSIVE CARE UNIT	31.00	0	84,722	0	12.00		
13.00	SUBPROVIDER - IRF	41.00	0	1,417	0	13.00		
14.00	NURSERY	43.00	0	36,316	0	14.00		
15.00	SKILLED NURSING FACILITY	44.00	0	21,193	0	15.00		
16.00	OPERATING ROOM	50.00	0	3,527,242	0	16.00		
17.00	RECOVERY ROOM	51.00	0	2,260	0	17.00		
18.00	ANESTHESIOLOGY	53.00	0	78,048	0	18.00		
19.00	RADIOLOGY-DIAGNOSTIC	54.00	0	8,843	0	19.00		
20.00	RADIOLOGY-THERAPEUTIC	55.00	0	2,088	0	20.00		
21.00	CT SCAN	57.00	0	33	0	21.00		
22.00	MRI	58.00	0	136	0	22.00		

RECLASSIFICATIONS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-6

Date/Time Prepared:
12/5/2019 9:25 am

		Decreases				wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00	10.00		
23.00	CARDIAC CATHETERIZATION	59.00	0	86,966	0		23.00
24.00	LABORATORY	60.00	0	1,595	0		24.00
25.00	RESPIRATORY THERAPY	65.00	0	16,409	0		25.00
26.00	PHYSICAL THERAPY	66.00	0	10,848	0		26.00
27.00	ELECTROCARDIOLOGY	69.00	0	2,852	0		27.00
28.00	CARDIAC REHABILITATION	76.97	0	577	0		28.00
29.00	CLINIC	90.00	0	8,068	0		29.00
30.00	EMERGENCY	91.00	0	48,963	0		30.00
31.00	OTHER	194.00	0	9,886	0		31.00
32.00	SUBPROVIDER - IPF	40.00	0	9,082	0		32.00
	TOTALS		0	4,368,080			
D - NURSEY							
1.00	ADULTS & PEDIATRICS	30.00	602,029	205,657	0		1.00
	TOTALS		602,029	205,657			
E - CAFETERIA							
1.00	DIETARY	10.00	819,153	1,346,748	0		1.00
	TOTALS		819,153	1,346,748			
F - PHYSICIAN DEPR CHAIRMAN							
1.00	I&R SERVICES-OTHER PRGM COSTS	22.00	847,086	90,085	0		1.00
	APPRV						
	TOTALS		847,086	90,085			
G - SALARY EARNED TIME OFF ACCRUAL							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	356,811	0		1.00
	TOTALS		0	356,811			
H - EQUIP DEPRECIATION							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	104,785	9		1.00
2.00	PURCHASING, RECEIVING & STORES	5.03	0	498,063	0		2.00
3.00	ADMINISTRATION & GENERAL	5.06	0	3,297,740	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	4,758	0		4.00
5.00	HOUSEKEEPING	9.00	0	20,737	0		5.00
6.00	DIETARY	10.00	0	64,467	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	55,615	0		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	73,041	0		8.00
9.00	PARAMED ED PRGM-(SPECIFY)	23.00	0	25,334	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	96,272	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	0	82,321	0		11.00
12.00	NURSERY	43.00	0	12,771	0		12.00
13.00	SKILLED NURSING FACILITY	44.00	0	8,580	0		13.00
14.00	OPERATING ROOM	50.00	0	754,480	0		14.00
15.00	RECOVERY ROOM	51.00	0	313	0		15.00
16.00	ANESTHESIOLOGY	53.00	0	290,548	0		16.00
17.00	RADIOLOGY-DIAGNOSTIC	54.00	0	453,244	0		17.00
18.00	RADIOLOGY-THERAPEUTIC	55.00	0	31,604	0		18.00
19.00	MRI	58.00	0	302,545	0		19.00
20.00	CARDIAC CATHETERIZATION	59.00	0	322,698	0		20.00
21.00	LABORATORY	60.00	0	87,799	0		21.00
22.00	RESPIRATORY THERAPY	65.00	0	48,810	0		22.00
23.00	PHYSICAL THERAPY	66.00	0	2,847	0		23.00
24.00	ELECTROCARDIOLOGY	69.00	0	29,869	0		24.00
25.00	ELECTROENCEPHALOGRAPHY	70.00	0	931	0		25.00
26.00	RENAL DIALYSIS	74.00	0	127	0		26.00
27.00	CARDIAC REHABILITATION	76.97	0	3,143	0		27.00
28.00	EMERGENCY	91.00	0	74,149	0		28.00
29.00	PARTIAL HOSPITALIZATION	91.01	0	12,376	0		29.00
30.00	OTHER	194.00	0	36,819	0		30.00
31.00	SUBPROVIDER - IPF	40.00	0	2,123	0		31.00
	TOTALS		0	6,798,909			
I - PHONES							
1.00	ADMINISTRATION & GENERAL	5.06	0	131,645	0		1.00
	TOTALS		0	131,645			
J - PHARMACY RESIDENCY COSTS							
1.00	PHARMACY	15.00	8,294	4,572	0		1.00
	TOTALS		8,294	4,572			
L - INTERNS AND RESIDENTS SALARY							
1.00	I&R SERVICES-OTHER PRGM COSTS	22.00	8,114,531	1,735,989	0		1.00
	APPRV						
	TOTALS		8,114,531	1,735,989			
M - BLOOD RECLASS							
1.00	LABORATORY	60.00	0	18,656	0		1.00
	TOTALS		0	18,656			
500.00	Grand Total: Decreases		10,391,093	24,714,177			500.00

RECLASSIFICATIONS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
12/5/2019 9:25 am

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
	A - DRUGS								
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	5,848,070	ADMINISTRATION & GENERAL	5.06	0	135	1.00
2.00		0.00	0		0 OPERATION OF PLANT	7.00	0	8	2.00
3.00		0.00	0		0 PHARMACY	15.00	0	4,040,947	3.00
4.00		0.00	0		0 MEDICAL RECORDS & LIBRARY	16.00	0	34,670	4.00
5.00		0.00	0		0 ADULTS & PEDIATRICS	30.00	0	282,522	5.00
6.00		0.00	0		0 INTENSIVE CARE UNIT	31.00	0	39,785	6.00
7.00		0.00	0		0 SUBPROVIDER - IRF	41.00	0	68	7.00
8.00		0.00	0		0 NURSERY	43.00	0	17,257	8.00
9.00		0.00	0		0 SKILLED NURSING FACILITY	44.00	0	12,172	9.00
10.00		0.00	0		0 OPERATING ROOM	50.00	0	188,046	10.00
11.00		0.00	0		0 RECOVERY ROOM	51.00	0	5,043	11.00
12.00		0.00	0		0 ANESTHESIOLOGY	53.00	0	218,984	12.00
13.00		0.00	0		0 RADIOLOGY-DIAGNOSTIC	54.00	0	15,382	13.00
14.00		0.00	0		0 RADIOLOGY-THERAPEUTIC	55.00	0	42,600	14.00
15.00		0.00	0		0 CT SCAN	57.00	0	23,169	15.00
16.00		0.00	0		0 MRI	58.00	0	24,890	16.00
17.00		0.00	0		0 CARDIAC CATHETERIZATION	59.00	0	77,112	17.00
18.00		0.00	0		0 LABORATORY	60.00	0	3,361	18.00
19.00		0.00	0		0 RESPIRATORY THERAPY	65.00	0	6,235	19.00
20.00		0.00	0		0 PHYSICAL THERAPY	66.00	0	2,409	20.00
21.00		0.00	0		0 ELECTROCARDIOLOGY	69.00	0	6,728	21.00
22.00		0.00	0		0 ELECTROENCEPHALOGRAPHY	70.00	0	5	22.00
23.00		0.00	0		0 CLINIC	90.00	0	6,324	23.00
24.00		0.00	0		0 EMERGENCY	91.00	0	100,925	24.00
25.00		0.00	0		0 OTHER	194.00	0	699,038	25.00
26.00		0.00	0		0 SUBPROVIDER - IPF	40.00	0	255	26.00
	TOTALS		0	5,848,070	TOTALS		0	5,848,070	
	B - IMPLANTS								
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	3,808,955	PHARMACY	15.00	0	319	1.00
2.00		0.00	0		0 MEDICAL RECORDS & LIBRARY	16.00	0	2,608	2.00
3.00		0.00	0		0 ADULTS & PEDIATRICS	30.00	0	39,483	3.00
4.00		0.00	0		0 INTENSIVE CARE UNIT	31.00	0	14,759	4.00
5.00		0.00	0		0 NURSERY	43.00	0	2,370	5.00
6.00		0.00	0		0 SKILLED NURSING FACILITY	44.00	0	1,061	6.00
7.00		0.00	0		0 OPERATING ROOM	50.00	0	3,151,151	7.00
8.00		0.00	0		0 RECOVERY ROOM	51.00	0	60	8.00
9.00		0.00	0		0 ANESTHESIOLOGY	53.00	0	14,137	9.00
10.00		0.00	0		0 RADIOLOGY-DIAGNOSTIC	54.00	0	1,539	10.00
11.00		0.00	0		0 CT SCAN	57.00	0	4,085	11.00
12.00		0.00	0		0 MRI	58.00	0	367	12.00
13.00		0.00	0		0 CARDIAC CATHETERIZATION	59.00	0	513,250	13.00
14.00		0.00	0		0 RESPIRATORY THERAPY	65.00	0	56	14.00
15.00		0.00	0		0 PHYSICAL THERAPY	66.00	0	370	15.00
16.00		0.00	0		0 ELECTROCARDIOLOGY	69.00	0	34	16.00
17.00		0.00	0		0 CLINIC	90.00	0	36,163	17.00
18.00		0.00	0		0 EMERGENCY	91.00	0	27,117	18.00
19.00		0.00	0		0 OTHER	194.00	0	8	19.00
20.00		0.00	0		0 SUBPROVIDER - IPF	40.00	0	18	20.00
	TOTALS		0	3,808,955	TOTALS		0	3,808,955	
	C - CHARGABLE SUPPLIES								
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	4,368,080	PURCHASING, RECEIVING&S TORES	5.03	0	57	1.00
2.00		0.00	0		0 ADMINISTRATION & GENERAL	5.06	0	24	2.00
3.00		0.00	0		0 OPERATION OF PLANT	7.00	0	55	3.00
4.00		0.00	0		0 HOUSEKEEPING	9.00	0	2,028	4.00
5.00		0.00	0		0 DIETARY	10.00	0	39	5.00
6.00		0.00	0		0 NURSING ADMINISTRATION	13.00	0	35	6.00
7.00		0.00	0		0 CENTRAL SERVICES & SUPPLY	14.00	0	3,300	7.00
8.00		0.00	0		0 PHARMACY	15.00	0	3,319	8.00
9.00		0.00	0		0 MEDICAL RECORDS & LIBRARY	16.00	0	3,038	9.00
10.00		0.00	0		0 I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	8,867	10.00

RECLASSIFICATIONS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
12/5/2019 9:25 am

Increases					Decreases				
Cost Center	Line #	Salary	Other		Cost Center	Line #	Salary	Other	
2.00	3.00	4.00	5.00		6.00	7.00	8.00	9.00	
11.00	0.00	0	0	0	ADULTS & PEDIATRICS	30.00	0	389,774	11.00
12.00	0.00	0	0	0	INTENSIVE CARE UNIT	31.00	0	84,722	12.00
13.00	0.00	0	0	0	SUBPROVIDER - IRF	41.00	0	1,417	13.00
14.00	0.00	0	0	0	NURSERY	43.00	0	36,316	14.00
15.00	0.00	0	0	0	SKILLED NURSING FACILITY	44.00	0	21,193	15.00
16.00	0.00	0	0	0	OPERATING ROOM	50.00	0	3,527,242	16.00
17.00	0.00	0	0	0	RECOVERY ROOM	51.00	0	2,260	17.00
18.00	0.00	0	0	0	ANESTHESIOLOGY	53.00	0	78,048	18.00
19.00	0.00	0	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	8,843	19.00
20.00	0.00	0	0	0	RADIOLOGY-THERAPEUTIC	55.00	0	2,088	20.00
21.00	0.00	0	0	0	CT SCAN	57.00	0	33	21.00
22.00	0.00	0	0	0	MRI	58.00	0	136	22.00
23.00	0.00	0	0	0	CARDIAC CATHETERIZATION	59.00	0	86,966	23.00
24.00	0.00	0	0	0	LABORATORY	60.00	0	1,595	24.00
25.00	0.00	0	0	0	RESPIRATORY THERAPY	65.00	0	16,409	25.00
26.00	0.00	0	0	0	PHYSICAL THERAPY	66.00	0	10,848	26.00
27.00	0.00	0	0	0	ELECTROCARDIOLOGY	69.00	0	2,852	27.00
28.00	0.00	0	0	0	CARDIAC REHABILITATION	76.97	0	577	28.00
29.00	0.00	0	0	0	CLINIC	90.00	0	8,068	29.00
30.00	0.00	0	0	0	EMERGENCY	91.00	0	48,963	30.00
31.00	0.00	0	0	0	OTHER	194.00	0	9,886	31.00
32.00	0.00	0	0	0	SUBPROVIDER - IPF	40.00	0	9,082	32.00
TOTALS			4,368,080	TOTALS			4,368,080		
D - NURSEY									
1.00	NURSERY	43.00	602,029	205,657	ADULTS & PEDIATRICS	30.00	602,029	205,657	1.00
TOTALS			602,029	205,657	TOTALS		602,029	205,657	
E - CAFETERIA									
1.00	CAFETERIA	11.00	819,153	1,346,748	DIETARY	10.00	819,153	1,346,748	1.00
TOTALS			819,153	1,346,748	TOTALS		819,153	1,346,748	
F - PHYSICIAN DEPR CHAIRMAN									
1.00	ADULTS & PEDIATRICS	30.00	847,086	90,085	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	847,086	90,085	1.00
TOTALS			847,086	90,085	TOTALS		847,086	90,085	
G - SALARY EARNED TIME OFF ACCRUAL									
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	356,811	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	356,811	1.00
TOTALS			356,811	0	TOTALS		0	356,811	
H - EQUIP DEPRECIATION									
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,798,909	CAP REL COSTS-BLDG & FIXT	1.00	0	104,785	1.00
2.00		0.00	0	0	PURCHASING, RECEIVING&S TORES	5.03	0	498,063	2.00
3.00		0.00	0	0	ADMINISTRATION & GENERAL	5.06	0	3,297,740	3.00
4.00		0.00	0	0	LAUNDRY & LINEN SERVICE	8.00	0	4,758	4.00
5.00		0.00	0	0	HOUSEKEEPING	9.00	0	20,737	5.00
6.00		0.00	0	0	DIETARY	10.00	0	64,467	6.00
7.00		0.00	0	0	NURSING ADMINISTRATION	13.00	0	55,615	7.00
8.00		0.00	0	0	CENTRAL SERVICES & SUPPLY	14.00	0	73,041	8.00
9.00		0.00	0	0	PARAMED ED PRGM- (SPECIFY)	23.00	0	25,334	9.00
10.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	96,272	10.00
11.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	82,321	11.00
12.00		0.00	0	0	NURSERY	43.00	0	12,771	12.00
13.00		0.00	0	0	SKILLED NURSING FACILITY	44.00	0	8,580	13.00
14.00		0.00	0	0	OPERATING ROOM	50.00	0	754,480	14.00
15.00		0.00	0	0	RECOVERY ROOM	51.00	0	313	15.00
16.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	290,548	16.00
17.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	453,244	17.00
18.00		0.00	0	0	RADIOLOGY-THERAPEUTIC	55.00	0	31,604	18.00
19.00		0.00	0	0	MRI	58.00	0	302,545	19.00
20.00		0.00	0	0	CARDIAC CATHETERIZATION	59.00	0	322,698	20.00
21.00		0.00	0	0	LABORATORY	60.00	0	87,799	21.00
22.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	48,810	22.00
23.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	2,847	23.00
24.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	29,869	24.00
25.00		0.00	0	0	ELECTROENCEPHALOGRAPHY	70.00	0	931	25.00
26.00		0.00	0	0	RENAL DIALYSIS	74.00	0	127	26.00

RECLASSIFICATIONS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
12/5/2019 9:25 am

Increases					Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
27.00		0.00	0	0	0 CARDIAC REHABILITATION	76.97	0	3,143	27.00
28.00		0.00	0	0	0 EMERGENCY	91.00	0	74,149	28.00
29.00		0.00	0	0	0 PARTIAL	91.01	0	12,376	29.00
					0 HOSPITALIZATION				
30.00		0.00	0	0	0 OTHER	194.00	0	36,819	30.00
31.00		0.00	0	0	0 SUBPROVIDER - IPF	40.00	0	2,123	31.00
	TOTALS		0	6,798,909	TOTALS		0	6,798,909	
I - PHONES									
1.00	NONPATIENT TELEPHONES	5.01	0	131,645	ADMINISTRATION & GENERAL	5.06	0	131,645	1.00
	TOTALS		0	131,645	TOTALS		0	131,645	
J - PHARMACY RESIDENCY COSTS									
1.00	PARAMED ED PRGM-(SPECIFY)	23.00	8,294	4,572	PHARMACY	15.00	8,294	4,572	1.00
	TOTALS		8,294	4,572	TOTALS		8,294	4,572	
L - INTERNS AND RESIDENTS SALARY									
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	8,114,531	1,735,989	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	8,114,531	1,735,989	1.00
	TOTALS		8,114,531	1,735,989	TOTALS		8,114,531	1,735,989	
M - BLOOD RECLASS									
1.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	18,656	LABORATORY	60.00	0	18,656	1.00
	TOTALS		0	18,656	TOTALS		0	18,656	
500.00	Grand Total: Increases		10,747,904	24,357,366	Grand Total: Decreases		10,391,093	24,714,177	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part I
Date/Time Prepared:
12/5/2019 9:25 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	26,070,000	0	0	0	0	1.00	
2.00	Land Improvements	407,464	54,864	0	54,864	0	2.00	
3.00	Buildings and Fixtures	65,496,084	6,127,314	0	6,127,314	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	10,726,892	1,738,785	0	1,738,785	0	5.00	
6.00	Movable Equipment	6,411,549	0	0	0	233,392	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	109,111,989	7,920,963	0	7,920,963	233,392	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	109,111,989	7,920,963	0	7,920,963	233,392	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	26,070,000	0				1.00	
2.00	Land Improvements	462,328	0				2.00	
3.00	Buildings and Fixtures	71,623,398	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	12,465,677	0				5.00	
6.00	Movable Equipment	6,178,157	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	116,799,560	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	116,799,560	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part II
Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	5,881,531	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,881,531	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	5,881,531				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	5,881,531				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part III
Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	102,700,440	0	102,700,440	0.941239	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,411,549	0	6,411,549	0.058761	0	2.00
3.00	Total (sum of lines 1-2)	109,111,989	0	109,111,989	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	6,904,429	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	15,538,284	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	22,442,713	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	834,133	0	0	0	7,738,562	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	15,538,284	2.00
3.00	Total (sum of lines 1-2)	834,133	0	0	0	23,276,846	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-8

Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		B	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-3,493,393	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,462,625			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	-4,855,116			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-1,013,816	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		0		0.00	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	A	1,127,683	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	8,739,375	CAP REL COSTS-MVBLE EQUIP	2.00	9	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
33.00	MISC INCOME	B	-444	NURSERY	43.00	0	33.00
34.00	MISC REVENUE	B	-7,456	RADIOLOGY-DIAGNOSTIC	54.00	0	34.00
38.00	MISC INCOME	A	-2,535	CLINIC	90.00	0	38.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-8

Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
39.00	MOONLIGHTERS	A	-309,149	I&R SERVICES-OTHER PRGM COSTS	22.00	0	39.00
				APPRV			
40.00	HOCR INTEREST INCOME	B	-6,430,114	ADMINISTRATION & GENERAL	5.06	0	40.00
42.00	PHYS FEES	A	-1,450,792	OTHER	194.00	0	42.00
43.02	MISC INCOME	B	-15	DIETARY	10.00	0	43.02
43.03	MISC INCOME	B	-3,132,878	ADMINISTRATION & GENERAL	5.06	0	43.03
43.04	MISC INCOME	B	-3,945	ADULTS & PEDIATRICS	30.00	0	43.04
43.05	MISC INCOME	B	-5,000	I&R SERVICES-OTHER PRGM COSTS	22.00	0	43.05
				APPRV			
43.10	MISC INCOME	B	-16,454	PHARMACY	15.00	0	43.10
44.00	MISC INCOME	B	-5,000	NURSING ADMINISTRATION	13.00	0	44.00
45.00	MISC INCOME	B	-102	RADIOLOGY-THERAPEUTIC	55.00	0	45.00
46.00	MISC INCOME	B	-337	SKILLED NURSING FACILITY	44.00	0	46.00
47.00	MISC INCOME	B	-2,280	LABORATORY	60.00	0	47.00
48.00	BENEFITS ON PART B DOCS	A	-313,911	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	48.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-15,638,304				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-8-1

Date/Time Prepared:
12/5/2019 9:25 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		1.00	CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	4,327,526	0 1.00
2.00		4.00	EMPLOYEE BENEFITS DEPARTMENT	EH&W	704,568	0 2.00
3.00		5.02	DATA PROCESSING	IT	5,455,442	0 3.00
3.01		5.03	PURCHASING, RECEIVING & STORES	PURCHASING	119,863	0 3.01
3.02		5.05	CASHIERING/ACCTS RECEIVABLE	BUSINESS OFFICE	1,848,823	0 3.02
3.03		5.06	ADMINISTRATION & GENERAL	ADMIN AND GENERAL	7,035,951	25,761,656 3.03
3.04		7.00	OPERATION OF PLANT	PLANT OPERATION	97,199	0 3.04
3.05		8.00	LAUNDRY & LINEN SERVICE	LAUNDRY	2,753	0 3.05
3.06		16.00	MEDICAL RECORDS & LIBRARY	HIMS	773,706	0 3.06
3.07		31.00	INTENSIVE CARE UNIT	ICU	478,913	0 3.07
4.00		60.00	LABORATORY	ALVERNO LAB	6,490,048	6,428,252 4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				27,334,792	32,189,908 5.00

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

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

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

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

6.00	B		100.00	PRESENCE CARE	100.00	6.00
7.00	C		66.67	ALVERNO LABS	66.67	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-8-1

Date/Time Prepared:
12/5/2019 9:25 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	4,327,526	11		1.00
2.00	704,568	0		2.00
3.00	5,455,442	0		3.00
3.01	119,863	0		3.01
3.02	1,848,823	0		3.02
3.03	-18,725,705	0		3.03
3.04	97,199	0		3.04
3.05	2,753	0		3.05
3.06	773,706	0		3.06
3.07	478,913	0		3.07
4.00	61,796	0		4.00
5.00	-4,855,116			5.00

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

	Related Organization(s) and/or Home Office	
	Type of Business	
	6.00	

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-8-2

Date/Time Prepared:
12/5/2019 9:25 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,929,710	1,881,610	48,100	179,000	344	1.00
2.00	43.00	NURSERY	11,520	11,520	0	0	0	2.00
3.00	44.00	SKILLED NURSING FACILITY	1,667	1,667	0	0	0	3.00
4.00	50.00	OPERATING ROOM	960,269	960,269	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	350,370	350,370	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	159,858	159,858	0	0	0	6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	226,221	226,221	0	0	0	7.00
8.00	60.00	LABORATORY	27,561	27,561	0	0	0	8.00
9.00	66.00	PHYSICAL THERAPY	8,175	8,175	0	0	0	9.00
10.00	69.00	ELECTROCARDIOLOGY	195,925	195,925	0	0	0	10.00
11.00	91.00	EMERGENCY	320,538	320,538	0	0	0	11.00
12.00	91.01	PARTIAL HOSPITALIZATION	24,071	24,071	0	0	0	12.00
13.00	5.06	ADMINISTRATION & GENERAL	424,019	80,294	343,725	179,000	1,716	13.00
200.00			4,639,904	4,248,079	391,825		2,060	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	29,604	1,480	0	0	0	1.00
2.00	43.00	NURSERY	0	0	0	0	0	2.00
3.00	44.00	SKILLED NURSING FACILITY	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	7.00
8.00	60.00	LABORATORY	0	0	0	0	0	8.00
9.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	9.00
10.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	10.00
11.00	91.00	EMERGENCY	0	0	0	0	0	11.00
12.00	91.01	PARTIAL HOSPITALIZATION	0	0	0	0	0	12.00
13.00	5.06	ADMINISTRATION & GENERAL	147,675	7,384	0	0	0	13.00
200.00			177,279	8,864	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	30.00	ADULTS & PEDIATRICS	0	29,604	18,496	1,900,106	1.00
2.00	43.00	NURSERY	0	0	0	11,520	2.00
3.00	44.00	SKILLED NURSING FACILITY	0	0	0	1,667	3.00
4.00	50.00	OPERATING ROOM	0	0	0	960,269	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	350,370	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	159,858	6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	226,221	7.00
8.00	60.00	LABORATORY	0	0	0	27,561	8.00
9.00	66.00	PHYSICAL THERAPY	0	0	0	8,175	9.00
10.00	69.00	ELECTROCARDIOLOGY	0	0	0	195,925	10.00
11.00	91.00	EMERGENCY	0	0	0	320,538	11.00
12.00	91.01	PARTIAL HOSPITALIZATION	0	0	0	24,071	12.00
13.00	5.06	ADMINISTRATION & GENERAL	0	147,675	196,050	276,344	13.00
200.00			0	177,279	214,546	4,462,625	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
			BLDG & FIXT	MVBLE EQUIP			
Net Expenses for Cost Allocation (from Wkst A col. 7)							
0			1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	7,738,562	7,738,562			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	15,538,284	15,538,284			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	950,952	0	950,952		4.00
5.01	00540	NONPATIENT TELEPHONES	131,645	0	0	131,645	5.01
5.02	00550	DATA PROCESSING	5,455,442	0	0	0	5.02
5.03	00560	PURCHASING, RECEIVING & STORES	-378,150	0	0	2,129	5.03
5.04	00570	ADMITTING	0	0	0	3,785	5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	1,848,823	1,870	3,755	0	5.05
5.06	00591	ADMINISTRATION & GENERAL	48,823,253	2,627,612	5,275,988	96,889	5.06
6.00	00600	MAINTENANCE & REPAIRS	50	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	2,609,471	276,889	555,966	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	713,671	16,979	34,093	1,864	8.00
9.00	00900	HOUSEKEEPING	3,396,003	299,897	602,164	11,589	9.00
10.00	01000	DIETARY	1,820,797	286,074	574,410	10,949	10.00
11.00	01100	CAFETERIA	1,152,085	0	0	11,602	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,647,878	29,441	59,114	17,814	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,366,064	0	0	2,743	14.00
15.00	01500	PHARMACY	2,625,475	54,304	109,037	27,054	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,080,748	114,247	229,397	1,132	16.00
17.00	01700	SOCIAL SERVICE	226,072	0	0	433	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	9,850,520	0	0	114,926	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	5,565,758	45,343	91,044	37,551	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	203,581	1,002	2,013	2,811	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	17,663,696	1,526,353	3,064,769	194,648	30.00
31.00	03100	INTENSIVE CARE UNIT	2,861,518	213,864	429,418	26,329	31.00
40.00	04000	SUBPROVIDER - IPF	3,573,194	218,561	438,850	37,666	40.00
41.00	04100	SUBPROVIDER - IRF	365,737	90,955	182,629	4,030	41.00
43.00	04300	NURSERY	2,840,576	52,853	106,123	32,114	43.00
44.00	04400	SKILLED NURSING FACILITY	2,550,451	227,013	455,821	27,844	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	12,721,029	594,977	1,194,657	75,558	50.00
51.00	05100	RECOVERY ROOM	660,779	30,952	62,148	7,696	51.00
53.00	05300	ANESTHESIOLOGY	-6,862	13,135	26,373	1,450	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,461,582	315,410	633,313	32,764	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,662,471	86,991	174,669	15,475	55.00
57.00	05700	CT SCAN	515,332	23,232	46,648	5,182	57.00
58.00	05800	MRI	375,116	12,791	25,682	4,261	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,117,491	147,263	295,690	15,779	59.00
60.00	06000	LABORATORY	6,528,953	163,225	327,741	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	438,594	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,455,032	48,080	96,541	13,572	65.00
66.00	06600	PHYSICAL THERAPY	2,387,176	98,046	196,867	28,847	66.00
69.00	06900	ELECTROCARDIOLOGY	435,029	0	0	5,072	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	65,847	568	1,141	742	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,368,080	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,808,955	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,848,070	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	322,660	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	105,939	0	0	1,229	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	610,907	8,138	16,340	6,991	90.00
91.00	09100	EMERGENCY	3,062,207	0	0	30,960	91.00
91.01	09101	PARTIAL HOSPITALIZATION	352,364	0	0	4,424	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	193,518,907	7,626,065	15,312,401	909,990	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	OTHER	2,833,497	112,497	225,883	40,962	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	194.01
200.00		Cross Foot Adjustments					200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	196,352,404	7,738,562	15,538,284	950,952	131,645	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description			DATA	PURCHASING, REC	ADMITTING	CASHIERING/ACC	Subtotal	
			PROCESSING	EIVING&STORES		TS RECEIVABLE		
			5.02	5.03	5.04	5.05	5A.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	5,455,442					5.02
5.03	00560	PURCHASING,RECEIVING&STORES	0	-376,021				5.03
5.04	00570	ADMITTING	0	0	3,785			5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	0	0	0	1,860,362		5.05
5.06	00591	ADMINISTRATION & GENERAL	5,455,442	0	0	0	62,295,270	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	50	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	3,447,767	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	767,080	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	4,310,363	9.00
10.00	01000	DIETARY	0	0	0	0	2,693,176	10.00
11.00	01100	CAFETERIA	0	0	0	0	1,165,106	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	1,759,924	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	1,369,398	14.00
15.00	01500	PHARMACY	0	0	0	0	2,818,236	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	1,430,019	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	228,279	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	9,965,446	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	5,745,965	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	209,407	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	1,047	279,545	22,750,165	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	114	31,396	3,567,252	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	87	24,176	4,292,534	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	8	2,270	648,349	41.00
43.00	04300	NURSERY	0	0	183	50,710	3,083,505	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	60	16,608	3,279,216	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	302	284,230	14,880,452	50.00
51.00	05100	RECOVERY ROOM	0	0	48	32,693	794,316	51.00
53.00	05300	ANESTHESIOLOGY	0	0	67	59,477	93,877	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	60	100,640	4,553,350	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	5	44,992	1,984,603	55.00
57.00	05700	CT SCAN	0	0	73	67,328	657,795	57.00
58.00	05800	MRI	0	0	23	33,426	451,299	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	111	58,578	2,634,912	59.00
60.00	06000	LABORATORY	0	0	314	166,407	7,193,500	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	20	7,029	445,643	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	79	23,523	1,638,483	65.00
66.00	06600	PHYSICAL THERAPY	0	0	94	29,751	2,744,093	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	87	56,565	498,645	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	3	4,139	73,978	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	173	103,826	4,472,079	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	158	72,874	3,881,987	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	516	190,677	6,039,263	73.00
74.00	07400	RENAL DIALYSIS	0	0	13	4,023	327,406	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,770	109,293	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	1	8,186	655,531	90.00
91.00	09100	EMERGENCY	0	0	136	102,860	3,199,120	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	2,663	359,451	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,455,442	0	3,782	1,860,362	193,515,583	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	0	0	3	0	3,212,842	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	-376,021	0	0	-376,021	201.00
202.00		TOTAL (sum lines 118 through 201)	5,455,442	-376,021	3,785	1,860,362	196,352,404	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			ADMINISTRATION & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.06	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL	62,295,270					5.06
6.00	00600	MAINTENANCE & REPAIRS	23	73				6.00
7.00	00700	OPERATION OF PLANT	1,597,668	4	5,045,439			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	355,459	0	17,729	1,140,268		8.00
9.00	00900	HOUSEKEEPING	1,997,388	4	313,132	0	6,620,887	9.00
10.00	01000	DIETARY	1,247,996	4	298,699	0	419,476	10.00
11.00	01100	CAFETERIA	539,901	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	815,535	0	30,740	0	43,169	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	634,568	0	0	585	0	14.00
15.00	01500	PHARMACY	1,305,948	1	56,700	4,827	79,626	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	662,659	2	119,289	0	167,523	16.00
17.00	01700	SOCIAL SERVICE	105,783	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	4,617,908	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,662,634	1	47,344	0	66,487	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	97,038	0	1,047	0	1,470	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,542,264	23	1,593,710	321,976	2,238,118	30.00
31.00	03100	INTENSIVE CARE UNIT	1,653,036	3	223,302	10,165	313,592	31.00
40.00	04000	SUBPROVIDER - IPF	1,989,126	3	228,206	66,829	320,480	40.00
41.00	04100	SUBPROVIDER - IRF	300,440	1	94,969	18,943	133,369	41.00
43.00	04300	NURSERY	1,428,872	1	55,185	81,723	77,499	43.00
44.00	04400	SKILLED NURSING FACILITY	1,519,562	3	237,032	73,568	332,874	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,895,482	9	621,234	230,186	872,425	50.00
51.00	05100	RECOVERY ROOM	368,080	0	32,318	11,765	45,385	51.00
53.00	05300	ANESTHESIOLOGY	43,502	0	13,714	0	19,260	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,109,986	5	329,329	116,166	462,492	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	919,649	1	90,830	34,238	127,556	55.00
57.00	05700	CT SCAN	304,817	0	24,258	0	34,066	57.00
58.00	05800	MRI	209,128	0	13,355	0	18,755	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,220,997	2	153,762	32,495	215,935	59.00
60.00	06000	LABORATORY	3,333,410	2	170,428	13	239,340	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	206,507	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	759,260	1	50,202	0	70,501	65.00
66.00	06600	PHYSICAL THERAPY	1,271,591	1	102,373	2,951	143,766	66.00
69.00	06900	ELECTROCARDIOLOGY	231,068	0	0	12,005	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	34,281	0	594	725	834	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,072,326	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,798,882	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,798,546	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	151,717	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	50,646	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	303,768	0	8,497	10,113	11,933	90.00
91.00	09100	EMERGENCY	1,482,447	0	0	104,711	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	166,567	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	60,806,465	71	4,927,978	1,133,984	6,455,931	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	1,488,805	2	117,461	6,284	164,956	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	62,295,270	73	5,045,439	1,140,268	6,620,887	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING, RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
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	4,659,351					10.00
11.00	01100	CAFETERIA	0	1,705,007				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	26,911	0	2,676,279		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,700	0	91	2,015,342	14.00
15.00	01500	PHARMACY	0	51,690	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,842	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,464	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	297,397	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	51,540	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	3,423	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,355,437	411,801	0	1,235,404	0	30.00
31.00	03100	INTENSIVE CARE UNIT	115,470	47,428	0	207,891	0	31.00
40.00	04000	SUBPROVIDER - IPF	500,839	88,720	0	151,561	0	40.00
41.00	04100	SUBPROVIDER - IRF	37,628	8,332	0	25,163	0	41.00
43.00	04300	NURSERY	0	57,374	0	220,675	0	43.00
44.00	04400	SKILLED NURSING FACILITY	649,977	63,402	0	121,702	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	153,973	0	341,368	0	50.00
51.00	05100	RECOVERY ROOM	0	13,262	0	54,626	0	51.00
53.00	05300	ANESTHESIOLOGY	0	5,382	0	436	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	63,897	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	35,135	0	17,881	0	55.00
57.00	05700	CT SCAN	0	10,355	0	0	0	57.00
58.00	05800	MRI	0	7,707	0	25	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	26,975	0	62,385	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	28,698	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	49,796	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	11,905	0	2,480	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,002	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,076,146	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	939,196	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	2,390	0	8,956	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	14,876	0	5,502	0	90.00
91.00	09100	EMERGENCY	0	61,830	0	203,626	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	9,257	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,659,351	1,620,464	0	2,659,772	2,015,342	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	0	84,543	0	16,507	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,659,351	1,705,007	0	2,676,279	2,015,342	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet B
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING, RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
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	4,317,028					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,382,334				16.00
17.00	01700	SOCIAL SERVICE	0	0	335,526			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			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	358,024	223,248	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	40,211	15,366	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	30,964	33,321	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	2,907	2,503	0	0	41.00
43.00	04300	NURSERY	0	64,947	17,844	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	21,270	43,244	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	363,717	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	41,871	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	76,174	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	128,893	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	57,624	0	0	0	55.00
57.00	05700	CT SCAN	0	86,230	0	0	0	57.00
58.00	05800	MRI	0	42,810	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	75,023	0	0	0	59.00
60.00	06000	LABORATORY	0	213,124	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	9,002	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	30,127	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	38,103	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	72,445	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,301	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	132,974	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	93,333	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,317,028	244,208	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	5,152	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	2,267	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	10,484	0	0	0	90.00
91.00	09100	EMERGENCY	0	131,738	0	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	3,411	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,317,028	2,382,334	335,526	0	0	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	0	0	0	0	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,317,028	2,382,334	335,526	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet B
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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
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	14,880,751					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		8,573,971				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			312,385			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,204,795	6,455,963	0	60,690,928	-17,660,758	30.00
31.00	03100	INTENSIVE CARE UNIT	961,008	553,712	0	7,708,436	-1,514,720	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	7,702,583	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	1,272,604	0	41.00
43.00	04300	NURSERY	0	0	0	5,087,625	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	6,341,850	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,597,526	920,460	0	26,876,832	-2,517,986	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,361,623	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	252,345	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	298,757	172,137	0	8,235,012	-470,894	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	3,267,517	0	55.00
57.00	05700	CT SCAN	0	0	0	1,117,521	0	57.00
58.00	05800	MRI	0	0	0	743,079	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	4,422,486	0	59.00
60.00	06000	LABORATORY	6,031	3,475	0	11,159,323	-9,506	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	661,152	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,577,272	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,352,674	0	66.00
69.00	06900	ELECTROCARDIOLOGY	118,216	68,114	0	1,014,878	-186,330	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	117,715	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7,753,525	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,713,398	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	312,385	13,711,430	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	484,275	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	173,552	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	10,454	6,024	0	1,037,182	-16,478	90.00
91.00	09100	EMERGENCY	683,964	394,086	0	6,261,522	-1,078,050	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	538,686	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,880,751	8,573,971	312,385	191,637,025	-23,454,722	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	0	0	0	5,091,400	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description		INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
		21.00	22.00				
201.00	Negative Cost Centers	0	0	0	-376,021	0	201.00
202.00	TOTAL (sum lines 118 through 201)	14,880,751	8,573,971	312,385	196,352,404	-23,454,722	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description			Total	
			26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00540	NONPATIENT TELEPHONES		5.01
5.02	00550	DATA PROCESSING		5.02
5.03	00560	PURCHASING, RECEIVING&STORES		5.03
5.04	00570	ADMITTING		5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE		5.05
5.06	00591	ADMINISTRATION & GENERAL		5.06
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	43,030,170	30.00
31.00	03100	INTENSIVE CARE UNIT	6,193,716	31.00
40.00	04000	SUBPROVIDER - IPF	7,702,583	40.00
41.00	04100	SUBPROVIDER - IRF	1,272,604	41.00
43.00	04300	NURSERY	5,087,625	43.00
44.00	04400	SKILLED NURSING FACILITY	6,341,850	44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	24,358,846	50.00
51.00	05100	RECOVERY ROOM	1,361,623	51.00
53.00	05300	ANESTHESIOLOGY	252,345	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,764,118	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,267,517	55.00
57.00	05700	CT SCAN	1,117,521	57.00
58.00	05800	MRI	743,079	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,422,486	59.00
60.00	06000	LABORATORY	11,149,817	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	661,152	63.00
65.00	06500	RESPIRATORY THERAPY	2,577,272	65.00
66.00	06600	PHYSICAL THERAPY	4,352,674	66.00
69.00	06900	ELECTROCARDIOLOGY	828,548	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	117,715	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,753,525	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,713,398	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,711,430	73.00
74.00	07400	RENAL DIALYSIS	484,275	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	76.00
76.97	07697	CARDIAC REHABILITATION	173,552	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699	LITHOTRIPSY	0	76.99
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1,020,704	90.00
91.00	09100	EMERGENCY	5,183,472	91.00
91.01	09101	PARTIAL HOSPITALIZATION	538,686	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	168,182,303	118.00
NONREIMBURSABLE COST CENTERS				
194.00	07950	OTHER	5,091,400	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	194.01
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	-376,021	201.00
202.00		TOTAL (sum lines 118 through 201)	172,897,682	202.00

COST ALLOCATION STATISTICS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet Non-CMS Wo
Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS SALARIES	4.00
5.01	NONPATIENT TELEPHONES	3	NUMBER OF PHONES	5.01
5.02	DATA PROCESSING	4	TIME SPENT	5.02
5.03	PURCHASING, RECEIVING&STORES	5	SUPPLY EXP ENSE	5.03
5.04	ADMITTING	6	INPATIENT REVENUE	5.04
5.05	CASHIERING/ACCTS RECEIVABLE	C	GROSS REVE NUE	5.05
5.06	ADMINISTRATION & GENERAL	-1	ACCUM. COST	5.06
6.00	MAINTENANCE & REPAIRS	1	SQUARE FEET	6.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	7	LAUNDRY PO UNDS	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	8	MEALS SERV ED)	10.00
11.00	CAFETERIA	9	MEALS SERV ED)	11.00
12.00	MAINTENANCE OF PERSONNEL	10	NUMBER HOUSED	12.00
13.00	NURSING ADMINISTRATION	11	DIRECT NRS G HRS)	13.00
14.00	CENTRAL SERVICES & SUPPLY	12	SUPPLY EXP ENSE	14.00
15.00	PHARMACY	13	COSTED REQ UIS)	15.00
16.00	MEDICAL RECORDS & LIBRARY	C	GROSS REVE NUE	16.00
17.00	SOCIAL SERVICE	14	PATIENT DA YS	17.00
19.00	NONPHYSICIAN ANESTHETISTS	15	ASSIGNED TIME	19.00
20.00	NURSING SCHOOL	16	ASSIGNED TIME	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRV	17	ASSIGNED T IME)	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	17	ASSIGNED T IME)	22.00
23.00	PARAMED ED PRGM-(SPECIFY)	18	ASSIGNED TIME	23.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	0	5.01
5.02	00550	DATA PROCESSING	0	0	0	0	5.02
5.03	00560	PURCHASING, RECEIVING&STORES	0	0	0	0	5.03
5.04	00570	ADMITTING	0	0	0	0	5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	0	1,870	3,755	5,625	5.05
5.06	00591	ADMINISTRATION & GENERAL	10,930,365	2,627,612	5,275,988	18,833,965	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	222	276,889	555,966	833,077	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	386	16,979	34,093	51,458	8.00
9.00	00900	HOUSEKEEPING	386	299,897	602,164	902,447	9.00
10.00	01000	DIETARY	14,238	286,074	574,410	874,722	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	5,216	29,441	59,114	93,771	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	61,274	0	0	61,274	14.00
15.00	01500	PHARMACY	98,507	54,304	109,037	261,848	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,429	114,247	229,397	348,073	16.00
17.00	01700	SOCIAL SERVICE	631	0	0	631	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	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	16,836	45,343	91,044	153,223	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	1,002	2,013	3,015	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	52,266	1,526,353	3,064,769	4,643,388	30.00
31.00	03100	INTENSIVE CARE UNIT	14,584	213,864	429,418	657,866	31.00
40.00	04000	SUBPROVIDER - IPF	0	218,561	438,850	657,411	40.00
41.00	04100	SUBPROVIDER - IRF	1,012	90,955	182,629	274,596	41.00
43.00	04300	NURSERY	734	52,853	106,123	159,710	43.00
44.00	04400	SKILLED NURSING FACILITY	19,459	227,013	455,821	702,293	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	120,027	594,977	1,194,657	1,909,661	50.00
51.00	05100	RECOVERY ROOM	305	30,952	62,148	93,405	51.00
53.00	05300	ANESTHESIOLOGY	4,461	13,135	26,373	43,969	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,866	315,410	633,313	953,589	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	11,620	86,991	174,669	273,280	55.00
57.00	05700	CT SCAN	66	23,232	46,648	69,946	57.00
58.00	05800	MRI	0	12,791	25,682	38,473	58.00
59.00	05900	CARDIAC CATHETERIZATION	10,491	147,263	295,690	453,444	59.00
60.00	06000	LABORATORY	13,442	163,225	327,741	504,408	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,745	48,080	96,541	148,366	65.00
66.00	06600	PHYSICAL THERAPY	16,826	98,046	196,867	311,739	66.00
69.00	06900	ELECTROCARDIOLOGY	5,699	0	0	5,699	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,674	568	1,141	3,383	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	108	0	0	108	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	1,356	8,138	16,340	25,834	90.00
91.00	09100	EMERGENCY	8,098	0	0	8,098	91.00
91.01	09101	PARTIAL HOSPITALIZATION	1,690	0	0	1,690	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,425,019	7,626,065	15,312,401	34,363,485	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	OTHER	56,406	112,497	225,883	394,786	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
202.00	TOTAL (sum lines 118 through 201)	11,481,425	7,738,562	15,538,284	34,758,271	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description			NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING, REC EIVING&STORES	ADMITTING	CASHIERING/ACC TS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	0					5.01
5.02	00550	DATA PROCESSING	0	0				5.02
5.03	00560	PURCHASING, RECEIVING&STORES	0	0	0			5.03
5.04	00570	ADMITTING	0	0	0	0		5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	0	0	0	0	5,625	5.05
5.06	00591	ADMINISTRATION & GENERAL	0	0	0	0	0	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	0	9.00
10.00	01000	DIETARY	0	0	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
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	0	0	0	885	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	99	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	77	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	7	41.00
43.00	04300	NURSERY	0	0	0	0	160	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	53	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	638	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	103	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	188	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	318	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	142	55.00
57.00	05700	CT SCAN	0	0	0	0	213	57.00
58.00	05800	MRI	0	0	0	0	106	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	185	59.00
60.00	06000	LABORATORY	0	0	0	0	527	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	22	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	74	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	94	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	179	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	13	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	329	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	231	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	603	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	13	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	6	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	26	90.00
91.00	09100	EMERGENCY	0	0	0	0	326	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	0	8	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		0	0	0	0	5,625	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	0	0	0	0	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)		0	0	0	0	5,625	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			ADMINISTRATION & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.06	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL	18,833,965					5.06
6.00	00600	MAINTENANCE & REPAIRS	7	7				6.00
7.00	00700	OPERATION OF PLANT	483,029	0	1,316,106			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	107,467	0	4,625	163,550		8.00
9.00	00900	HOUSEKEEPING	603,878	0	81,681	0	1,588,006	9.00
10.00	01000	DIETARY	377,311	0	77,916	0	100,610	10.00
11.00	01100	CAFETERIA	163,230	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	246,564	0	8,019	0	10,354	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	191,851	0	0	84	0	14.00
15.00	01500	PHARMACY	394,832	0	14,790	692	19,098	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	200,344	0	31,117	0	40,180	16.00
17.00	01700	SOCIAL SERVICE	31,982	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	1,396,149	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	805,004	0	12,350	0	15,947	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	29,338	0	273	0	353	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,187,288	6	415,718	46,181	536,811	30.00
31.00	03100	INTENSIVE CARE UNIT	499,768	0	58,248	1,458	75,214	31.00
40.00	04000	SUBPROVIDER - IPF	601,380	0	59,528	9,585	76,866	40.00
41.00	04100	SUBPROVIDER - IRF	90,833	0	24,773	2,717	31,988	41.00
43.00	04300	NURSERY	431,996	0	14,395	11,722	18,588	43.00
44.00	04400	SKILLED NURSING FACILITY	459,415	0	61,830	10,552	79,839	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,084,736	1	162,049	33,016	209,249	50.00
51.00	05100	RECOVERY ROOM	111,283	0	8,430	1,688	10,885	51.00
53.00	05300	ANESTHESIOLOGY	13,152	0	3,577	0	4,619	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	637,920	0	85,906	16,662	110,928	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	278,041	0	23,693	4,911	30,594	55.00
57.00	05700	CT SCAN	92,156	0	6,328	0	8,171	57.00
58.00	05800	MRI	63,227	0	3,484	0	4,498	58.00
59.00	05900	CARDIAC CATHETERIZATION	369,149	0	40,109	4,661	51,791	59.00
60.00	06000	LABORATORY	1,007,802	0	44,456	2	57,405	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	62,434	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	229,550	0	13,095	0	16,910	65.00
66.00	06600	PHYSICAL THERAPY	384,445	0	26,704	423	34,482	66.00
69.00	06900	ELECTROCARDIOLOGY	69,860	0	0	1,722	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	10,364	0	155	104	200	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	626,534	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	543,862	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	846,095	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	45,869	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	15,312	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	91,839	0	2,217	1,450	2,862	90.00
91.00	09100	EMERGENCY	448,194	0	0	15,019	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	50,359	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,383,849	7	1,285,466	162,649	1,548,442	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	450,116	0	30,640	901	39,564	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	18,833,965	7	1,316,106	163,550	1,588,006	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING, RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
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	1,430,559					10.00
11.00	01100	CAFETERIA	0	163,230				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	2,576	0	361,284		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,024	0	12	254,245	14.00
15.00	01500	PHARMACY	0	4,949	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	272	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	140	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	28,472	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	4,934	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	328	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,030,219	39,422	0	166,773	0	30.00
31.00	03100	INTENSIVE CARE UNIT	35,453	4,541	0	28,064	0	31.00
40.00	04000	SUBPROVIDER - IPF	153,772	8,494	0	20,460	0	40.00
41.00	04100	SUBPROVIDER - IRF	11,553	798	0	3,397	0	41.00
43.00	04300	NURSERY	0	5,493	0	29,790	0	43.00
44.00	04400	SKILLED NURSING FACILITY	199,562	6,070	0	16,429	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	14,741	0	46,083	0	50.00
51.00	05100	RECOVERY ROOM	0	1,270	0	7,374	0	51.00
53.00	05300	ANESTHESIOLOGY	0	515	0	59	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,117	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	3,364	0	2,414	0	55.00
57.00	05700	CT SCAN	0	991	0	0	0	57.00
58.00	05800	MRI	0	738	0	3	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,583	0	8,422	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	2,747	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	4,767	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,140	0	335	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	192	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	135,761	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	118,484	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	229	0	1,209	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	1,424	0	743	0	90.00
91.00	09100	EMERGENCY	0	5,919	0	27,489	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	886	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,430,559	155,136	0	359,056	254,245	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	0	8,094	0	2,228	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,430,559	163,230	0	361,284	254,245	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING, RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
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	696,209					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	619,986				16.00
17.00	01700	SOCIAL SERVICE	0	0	32,753			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			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	93,139	21,793			30.00
31.00	03100	INTENSIVE CARE UNIT	0	10,461	1,500			31.00
40.00	04000	SUBPROVIDER - IPF	0	8,055	3,253			40.00
41.00	04100	SUBPROVIDER - IRF	0	756	244			41.00
43.00	04300	NURSERY	0	16,896	1,742			43.00
44.00	04400	SKILLED NURSING FACILITY	0	5,533	4,221			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	94,849	0			50.00
51.00	05100	RECOVERY ROOM	0	10,893	0			51.00
53.00	05300	ANESTHESIOLOGY	0	19,817	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	33,531	0			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	14,991	0			55.00
57.00	05700	CT SCAN	0	22,433	0			57.00
58.00	05800	MRI	0	11,137	0			58.00
59.00	05900	CARDIAC CATHETERIZATION	0	19,517	0			59.00
60.00	06000	LABORATORY	0	55,444	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	2,342	0			63.00
65.00	06500	RESPIRATORY THERAPY	0	7,837	0			65.00
66.00	06600	PHYSICAL THERAPY	0	9,912	0			66.00
69.00	06900	ELECTROCARDIOLOGY	0	18,846	0			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,379	0			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	34,593	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	24,280	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	696,209	63,530	0			73.00
74.00	07400	RENAL DIALYSIS	0	1,340	0			74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0			76.00
76.97	07697	CARDIAC REHABILITATION	0	590	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	0	2,727	0			90.00
91.00	09100	EMERGENCY	0	34,271	0			91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	887	0			91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	696,209	619,986	32,753	0	0	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	0	0	0			194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0			194.01
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	696,209	619,986	32,753	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
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	1,424,621					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		991,458				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			33,307			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				10,181,623	0	30.00
31.00	03100	INTENSIVE CARE UNIT				1,372,672	0	31.00
40.00	04000	SUBPROVIDER - IPF				1,598,881	0	40.00
41.00	04100	SUBPROVIDER - IRF				441,662	0	41.00
43.00	04300	NURSERY				690,492	0	43.00
44.00	04400	SKILLED NURSING FACILITY				1,545,797	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				4,555,023	0	50.00
51.00	05100	RECOVERY ROOM				245,331	0	51.00
53.00	05300	ANESTHESIOLOGY				85,896	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				1,844,971	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC				631,430	0	55.00
57.00	05700	CT SCAN				200,238	0	57.00
58.00	05800	MRI				121,666	0	58.00
59.00	05900	CARDIAC CATHETERIZATION				949,861	0	59.00
60.00	06000	LABORATORY				1,670,044	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.				64,798	0	63.00
65.00	06500	RESPIRATORY THERAPY				418,579	0	65.00
66.00	06600	PHYSICAL THERAPY				772,566	0	66.00
69.00	06900	ELECTROCARDIOLOGY				97,781	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY				15,790	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				797,217	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				686,857	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				1,606,437	0	73.00
74.00	07400	RENAL DIALYSIS				47,222	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER				0	0	76.00
76.97	07697	CARDIAC REHABILITATION				17,454	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				129,122	0	90.00
91.00	09100	EMERGENCY				539,316	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION				53,830	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	31,382,556	0	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER				926,329	0	194.00
194.01	07951	LAKESHORE GUEST UNIT				0	0	194.01
200.00		Cross Foot Adjustments	1,424,621	991,458	33,307	2,449,386	0	200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description		INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
		21.00	22.00				
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	1,424,621	991,458	33,307	34,758,271	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description			Total	
			26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00540	NONPATIENT TELEPHONES		5.01
5.02	00550	DATA PROCESSING		5.02
5.03	00560	PURCHASING, RECEIVING&STORES		5.03
5.04	00570	ADMITTING		5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE		5.05
5.06	00591	ADMINISTRATION & GENERAL		5.06
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	10,181,623	30.00
31.00	03100	INTENSIVE CARE UNIT	1,372,672	31.00
40.00	04000	SUBPROVIDER - IPF	1,598,881	40.00
41.00	04100	SUBPROVIDER - IRF	441,662	41.00
43.00	04300	NURSERY	690,492	43.00
44.00	04400	SKILLED NURSING FACILITY	1,545,797	44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	4,555,023	50.00
51.00	05100	RECOVERY ROOM	245,331	51.00
53.00	05300	ANESTHESIOLOGY	85,896	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,844,971	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	631,430	55.00
57.00	05700	CT SCAN	200,238	57.00
58.00	05800	MRI	121,666	58.00
59.00	05900	CARDIAC CATHETERIZATION	949,861	59.00
60.00	06000	LABORATORY	1,670,044	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	64,798	63.00
65.00	06500	RESPIRATORY THERAPY	418,579	65.00
66.00	06600	PHYSICAL THERAPY	772,566	66.00
69.00	06900	ELECTROCARDIOLOGY	97,781	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	15,790	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	797,217	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	686,857	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,606,437	73.00
74.00	07400	RENAL DIALYSIS	47,222	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	76.00
76.97	07697	CARDIAC REHABILITATION	17,454	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699	LITHOTRIPSY	0	76.99
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	129,122	90.00
91.00	09100	EMERGENCY	539,316	91.00
91.01	09101	PARTIAL HOSPITALIZATION	53,830	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,382,556	118.00
NONREIMBURSABLE COST CENTERS				
194.00	07950	OTHER	926,329	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	194.01
200.00		Cross Foot Adjustments	2,449,386	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	34,758,271	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	DATA PROCESSING (TIME SPENT)	
			BLDG & FIXT (SQUARE FEET)	MBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	517,294					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		517,294				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	67,145,492			4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	1,113		5.01
5.02	00550	DATA PROCESSING	0	0	0	0	100	5.02
5.03	00560	PURCHASING, RECEIVING & STORES	0	0	0	18	0	5.03
5.04	00570	ADMITTING	0	0	0	32	0	5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	125	125	0	50	0	5.05
5.06	00591	ADMINISTRATION & GENERAL	175,646	175,646	6,840,990	136	100	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	18,509	18,509	0	46	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,135	1,135	131,606	4	0	8.00
9.00	00900	HOUSEKEEPING	20,047	20,047	818,238	6	0	9.00
10.00	01000	DIETARY	19,123	19,123	773,092	8	0	10.00
11.00	01100	CAFETERIA	0	0	819,153	12	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,968	1,968	1,257,818	48	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	193,705	5	0	14.00
15.00	01500	PHARMACY	3,630	3,630	1,910,166	20	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,637	7,637	79,935	38	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	30,545	15	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	8,114,531	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	3,031	3,031	2,651,317	53	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	67	67	198,506	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	102,031	102,031	13,745,446	170	0	30.00
31.00	03100	INTENSIVE CARE UNIT	14,296	14,296	1,859,027	39	0	31.00
40.00	04000	SUBPROVIDER - IPF	14,610	14,610	2,659,497	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	6,080	6,080	284,546	23	0	41.00
43.00	04300	NURSERY	3,533	3,533	2,267,459	8	0	43.00
44.00	04400	SKILLED NURSING FACILITY	15,175	15,175	1,965,978	12	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	39,772	39,772	5,334,876	82	0	50.00
51.00	05100	RECOVERY ROOM	2,069	2,069	543,417	0	0	51.00
53.00	05300	ANESTHESIOLOGY	878	878	102,402	2	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,084	21,084	2,313,384	81	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,815	5,815	1,092,650	0	0	55.00
57.00	05700	CT SCAN	1,553	1,553	365,886	0	0	57.00
58.00	05800	MRI	855	855	300,840	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,844	9,844	1,114,097	0	0	59.00
60.00	06000	LABORATORY	10,911	10,911	0	58	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,214	3,214	958,250	14	0	65.00
66.00	06600	PHYSICAL THERAPY	6,554	6,554	2,036,784	28	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	358,087	16	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	38	38	52,416	13	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	6	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	86,742	3	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	544	544	493,641	42	0	90.00
91.00	09100	EMERGENCY	0	0	2,185,961	25	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	312,329	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	509,774	509,774	64,253,317	1,113	100	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	7,520	7,520	2,892,175	0	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	DATA PROCESSING (TIME SPENT)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5.01	5.02	
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	7,738,562	15,538,284	950,952	131,645	5,455,442	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.959698	30.037627	0.014163	118.279425	54,554.420000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	0.000000	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: 14-0224

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description		PURCHASING, RECEIVING & STORES (SUPPLY EXPENSE)	ADMITTING (INPATIENT REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	ADMINISTRATION & GENERAL (ACCUM. COST)	
		5.03	5.04	5.05	5A.06	5.06	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING, RECEIVING & STORES	5,895,782				5.03
5.04	00570	ADMITTING	0	456,662,267			5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	0	0	841,037,673		5.05
5.06	00591	ADMINISTRATION & GENERAL	91,648	0	0	-62,295,270	134,433,155
6.00	00600	MAINTENANCE & REPAIRS	6	0	0	0	50
7.00	00700	OPERATION OF PLANT	145	0	0	0	3,447,767
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	767,080
9.00	00900	HOUSEKEEPING	4,956	0	0	0	4,310,363
10.00	01000	DIETARY	12,277	0	0	0	2,693,176
11.00	01100	CAFETERIA	0	0	0	0	1,165,106
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	1,911	0	0	0	1,759,924
14.00	01400	CENTRAL SERVICES & SUPPLY	78,913	0	0	0	1,369,398
15.00	01500	PHARMACY	35,359	0	0	0	2,818,236
16.00	01600	MEDICAL RECORDS & LIBRARY	30,550	0	0	0	1,430,019
17.00	01700	SOCIAL SERVICE	475	0	0	0	228,279
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	9,965,446
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	89,329	0	0	0	5,745,965
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	209,407
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	366,587	114,218,159	126,376,422	0	22,750,165
31.00	03100	INTENSIVE CARE UNIT	58,425	14,193,669	14,193,669	0	3,567,252
40.00	04000	SUBPROVIDER - IPF	79,765	10,929,596	10,929,596	0	4,292,534
41.00	04100	SUBPROVIDER - IRF	3,243	1,026,037	1,026,037	0	648,349
43.00	04300	NURSERY	22,414	22,925,150	22,925,150	0	3,083,505
44.00	04400	SKILLED NURSING FACILITY	49,483	7,508,060	7,508,060	0	3,279,216
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	402,239	37,770,095	128,500,654	0	14,880,452
51.00	05100	RECOVERY ROOM	5,509	6,061,030	14,779,661	0	794,316
53.00	05300	ANESTHESIOLOGY	10,654	8,333,226	26,888,253	0	93,877
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,727	7,464,341	45,497,093	0	4,553,350
55.00	05500	RADIOLOGY-THERAPEUTIC	9,383	587,039	20,340,125	0	1,984,603
57.00	05700	CT SCAN	15,883	9,159,022	30,437,809	0	657,795
58.00	05800	MRI	8,895	2,880,465	15,111,078	0	451,299
59.00	05900	CARDIAC CATHETERIZATION	32,839	13,930,263	26,481,969	0	2,634,912
60.00	06000	LABORATORY	5,012	39,304,346	75,229,133	0	7,193,500
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	200	2,560,671	3,177,593	0	445,643
65.00	06500	RESPIRATORY THERAPY	3,049	9,866,225	10,634,262	0	1,638,483
66.00	06600	PHYSICAL THERAPY	681	11,719,884	13,449,627	0	2,744,093
69.00	06900	ELECTROCARDIOLOGY	3,451	10,812,650	25,571,683	0	498,645
70.00	07000	ELECTROENCEPHALOGRAPHY	552	382,556	1,871,235	0	73,978
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,363,781	21,642,821	46,937,417	0	4,472,079
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	19,703,069	32,945,035	0	3,881,987
73.00	07300	DRUGS CHARGED TO PATIENTS	0	64,540,246	86,201,306	0	6,039,263
74.00	07400	RENAL DIALYSIS	0	1,664,368	1,818,727	0	327,406
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	101	1,124	800,336	0	109,293
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,800	93,401	3,700,607	0	655,531
91.00	09100	EMERGENCY	47,490	17,028,070	46,501,067	0	3,199,120
91.01	09101	PARTIAL HOSPITALIZATION	0	3,175	1,204,069	0	359,451
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,861,732	456,308,758	841,037,673	-62,295,270	131,220,313
NONREIMBURSABLE COST CENTERS							
194.00	07950	OTHER	34,050	353,509	0	0	3,212,842
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	-376,021	3,785	1,860,362		62,295,270

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description		PURCHASING, RECEIVING & STORES (SUPPLY EXPENSE)	ADMITTING (INPATIENT REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	ADMINISTRATION & GENERAL (ACCUM. COST)	
		5.03	5.04	5.05	5A.06	5.06	
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000008	0.002212		0.463392	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	0	5,625		18,833,965	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.000007		0.140099	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: 14-0224

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY PO UNDS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERV ED))	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING, RECEIVING&STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE					5.05
5.06	00591	ADMINISTRATION & GENERAL					5.06
6.00	00600	MAINTENANCE & REPAIRS	341,523				6.00
7.00	00700	OPERATION OF PLANT	18,509	323,014			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,135	1,135	941,163		8.00
9.00	00900	HOUSEKEEPING	20,047	20,047	0	301,832	9.00
10.00	01000	DIETARY	19,123	19,123	0	19,123	118,875
11.00	01100	CAFETERIA	0	0	0	0	0
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	1,968	1,968	0	1,968	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	483	0	0
15.00	01500	PHARMACY	3,630	3,630	3,984	3,630	0
16.00	01600	MEDICAL RECORDS & LIBRARY	7,637	7,637	0	7,637	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	3,031	3,031	0	3,031	0
23.00	02300	PARAMED ED PRGM- (SPECIFY)	67	67	0	67	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	102,031	102,031	265,754	102,031	85,608
31.00	03100	INTENSIVE CARE UNIT	14,296	14,296	8,390	14,296	2,946
40.00	04000	SUBPROVIDER - IPF	14,610	14,610	55,160	14,610	12,778
41.00	04100	SUBPROVIDER - IRF	6,080	6,080	15,635	6,080	960
43.00	04300	NURSERY	3,533	3,533	67,453	3,533	0
44.00	04400	SKILLED NURSING FACILITY	15,175	15,175	60,722	15,175	16,583
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	39,772	39,772	189,993	39,772	0
51.00	05100	RECOVERY ROOM	2,069	2,069	9,711	2,069	0
53.00	05300	ANESTHESIOLOGY	878	878	0	878	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,084	21,084	95,882	21,084	0
55.00	05500	RADIOLOGY-THERAPEUTIC	5,815	5,815	28,260	5,815	0
57.00	05700	CT SCAN	1,553	1,553	0	1,553	0
58.00	05800	MRI	855	855	0	855	0
59.00	05900	CARDIAC CATHETERIZATION	9,844	9,844	26,821	9,844	0
60.00	06000	LABORATORY	10,911	10,911	11	10,911	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	3,214	3,214	0	3,214	0
66.00	06600	PHYSICAL THERAPY	6,554	6,554	2,436	6,554	0
69.00	06900	ELECTROCARDIOLOGY	0	0	9,909	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	38	38	598	38	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	544	544	8,347	544	0
91.00	09100	EMERGENCY	0	0	86,427	0	0
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	334,003	315,494	935,976	294,312	118,875
NONREIMBURSABLE COST CENTERS							
194.00	07950	OTHER	7,520	7,520	5,187	7,520	0
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	73	5,045,439	1,140,268	6,620,887	4,659,351

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY PO UNDS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERV ED))	
		6.00	7.00	8.00	9.00	10.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000214	15.619877	1.211552	21.935670	39.195382	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	7	1,316,106	163,550	1,588,006	1,430,559	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000020	4.074455	0.173774	5.261225	12.034145	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: 14-0224

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description			CAFETERIA (MEALS SERV ED))	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRS G HRS))	CENTRAL SERVICES & SUPPLY (SUPPLY EXP ENSE)	PHARMACY (COSTED REQ UIS))	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
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	79,197					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	1,250	0	527,748			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	497	0	18	8,172,221		14.00
15.00	01500	PHARMACY	2,401	0	0	0	5,845,147	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	132	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	68	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	13,814	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,394	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	159	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	19,128	0	243,615	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,203	0	40,995	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	4,121	0	29,887	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	387	0	4,962	0	0	41.00
43.00	04300	NURSERY	2,665	0	43,516	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,945	0	23,999	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,152	0	67,316	0	0	50.00
51.00	05100	RECOVERY ROOM	616	0	10,772	0	0	51.00
53.00	05300	ANESTHESIOLOGY	250	0	86	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,968	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,632	0	3,526	0	0	55.00
57.00	05700	CT SCAN	481	0	0	0	0	57.00
58.00	05800	MRI	358	0	5	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,253	0	12,302	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,333	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,313	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	553	0	489	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	93	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,363,781	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,808,440	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	5,845,147	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	111	0	1,766	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	691	0	1,085	0	0	90.00
91.00	09100	EMERGENCY	2,872	0	40,154	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	430	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	75,270	0	524,493	8,172,221	5,845,147	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	3,927	0	3,255	0	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description		CAFETERIA (MEALS SERVED))	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRS G HRS))	CENTRAL SERVICES & SUPPLY (SUPPLY EXP ENSE)	PHARMACY (COSTED REQ UIS))	
		11.00	12.00	13.00	14.00	15.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	1,705,007	0	2,676,279	2,015,342	4,317,028	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	21.528682	0.000000	5.071131	0.246609	0.738566	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	163,230	0	361,284	254,245	696,209	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	2.061063	0.000000	0.684577	0.031111	0.119109	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: 14-0224

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	SOCIAL SERVICE (PATIENT DA YS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED T IME))	
			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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
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	841,037,673					16.00
17.00	01700	SOCIAL SERVICE	0	51,465				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			37,008	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	126,376,422	34,243	0	0	27,866	30.00
31.00	03100	INTENSIVE CARE UNIT	14,193,669	2,357	0	0	2,390	31.00
40.00	04000	SUBPROVIDER - IPF	10,929,596	5,111	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	1,026,037	384	0	0	0	41.00
43.00	04300	NURSERY	22,925,150	2,737	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	7,508,060	6,633	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	128,500,654	0	0	0	3,973	50.00
51.00	05100	RECOVERY ROOM	14,779,661	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	26,888,253	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	45,497,093	0	0	0	743	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	20,340,125	0	0	0	0	55.00
57.00	05700	CT SCAN	30,437,809	0	0	0	0	57.00
58.00	05800	MRI	15,111,078	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	26,481,969	0	0	0	0	59.00
60.00	06000	LABORATORY	75,229,133	0	0	0	15	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,177,593	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	10,634,262	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	13,449,627	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	25,571,683	0	0	0	294	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,871,235	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	46,937,417	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,945,035	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	86,201,306	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,818,727	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	800,336	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	3,700,607	0	0	0	26	90.00
91.00	09100	EMERGENCY	46,501,067	0	0	0	1,701	91.00
91.01	09101	PARTIAL HOSPITALIZATION	1,204,069	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	841,037,673	51,465	0	0	37,008	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	0	0	0	0	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS	SERVICES-SALARY & FRINGES APPROV (ASSIGNED TIME))	
201.00	Negative Cost Centers							201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,382,334	335,526	0	0	14,880,751		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.002833	6.519499	0.000000	0.000000	402.095520		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	619,986	32,753	0	0	1,424,621		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000737	0.636413	0.000000	0.000000	38.494947		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: 14-0224

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED T IME))		
			22.00	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
5.01	00540	NONPATIENT TELEPHONES			5.01
5.02	00550	DATA PROCESSING			5.02
5.03	00560	PURCHASING,RECEIVING&STORES			5.03
5.04	00570	ADMITTING			5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE			5.05
5.06	00591	ADMINISTRATION & GENERAL			5.06
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	37,008		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		100	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	27,866	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,390	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,973	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	743	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	15	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	294	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	100	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	76.00
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	26	0	90.00
91.00	09100	EMERGENCY	1,701	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,008	100	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07950	OTHER	0	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	194.01
200.00		Cross Foot Adjustments			200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description		INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)		
		SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME))			
		22.00	23.00		
201.00	Negative Cost Centers				201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	8,573,971	312,385		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	231.678853	3,123.850000		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	991,458	33,307		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	26.790370	333.070000		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: 14-0224	Period: From 07/01/2018 To 06/30/2019	Worksheet C Part I Date/Time Prepared: 12/5/2019 9:25 am			
				Title XVIII	Hospital	PPS			
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	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	43,030,170		43,030,170	18,496	43,048,666	30.00	
31.00	03100	INTENSIVE CARE UNIT	6,193,716		6,193,716	0	6,193,716	31.00	
40.00	04000	SUBPROVIDER - IPF	7,702,583		7,702,583	0	7,702,583	40.00	
41.00	04100	SUBPROVIDER - IRF	1,272,604		1,272,604	0	1,272,604	41.00	
43.00	04300	NURSERY	5,087,625		5,087,625	0	5,087,625	43.00	
44.00	04400	SKILLED NURSING FACILITY	6,341,850		6,341,850	0	6,341,850	44.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	24,358,846		24,358,846	0	24,358,846	50.00	
51.00	05100	RECOVERY ROOM	1,361,623		1,361,623	0	1,361,623	51.00	
53.00	05300	ANESTHESIOLOGY	252,345		252,345	0	252,345	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,764,118		7,764,118	0	7,764,118	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	3,267,517		3,267,517	0	3,267,517	55.00	
57.00	05700	CT SCAN	1,117,521		1,117,521	0	1,117,521	57.00	
58.00	05800	MRI	743,079		743,079	0	743,079	58.00	
59.00	05900	CARDIAC CATHETERIZATION	4,422,486		4,422,486	0	4,422,486	59.00	
60.00	06000	LABORATORY	11,149,817		11,149,817	0	11,149,817	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	661,152		661,152	0	661,152	63.00	
65.00	06500	RESPIRATORY THERAPY	2,577,272	0	2,577,272	0	2,577,272	65.00	
66.00	06600	PHYSICAL THERAPY	4,352,674	0	4,352,674	0	4,352,674	66.00	
69.00	06900	ELECTROCARDIOLOGY	828,548		828,548	0	828,548	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	117,715		117,715	0	117,715	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,753,525		7,753,525	0	7,753,525	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,713,398		6,713,398	0	6,713,398	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	13,711,430		13,711,430	0	13,711,430	73.00	
74.00	07400	RENAL DIALYSIS	484,275		484,275	0	484,275	74.00	
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0		0	0	0	76.00	
76.97	07697	CARDIAC REHABILITATION	173,552		173,552	0	173,552	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	1,020,704		1,020,704	0	1,020,704	90.00	
91.00	09100	EMERGENCY	5,183,472		5,183,472	0	5,183,472	91.00	
91.01	09101	PARTIAL HOSPITALIZATION	538,686		538,686	0	538,686	91.01	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,446,700		3,446,700		3,446,700	92.00	
200.00		Subtotal (see instructions)	171,629,003	0	171,629,003	18,496	171,647,499	200.00	
201.00		Less Observation Beds	3,446,700		3,446,700		3,446,700	201.00	
202.00		Total (see instructions)	168,182,303	0	168,182,303	18,496	168,200,799	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
12/5/2019 9:25 am

			Title XVIII			Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	114,218,159		114,218,159			30.00
31.00	03100	INTENSIVE CARE UNIT	14,193,669		14,193,669			31.00
40.00	04000	SUBPROVIDER - IPF	10,929,596		10,929,596			40.00
41.00	04100	SUBPROVIDER - IRF	1,026,037		1,026,037			41.00
43.00	04300	NURSERY	22,925,150		22,925,150			43.00
44.00	04400	SKILLED NURSING FACILITY	7,508,060		7,508,060			44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	37,770,095	90,730,559	128,500,654	0.189562	0.000000	50.00
51.00	05100	RECOVERY ROOM	6,061,030	8,718,631	14,779,661	0.092128	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	8,333,226	18,555,027	26,888,253	0.009385	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,464,341	38,032,752	45,497,093	0.170651	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	587,039	19,753,086	20,340,125	0.160644	0.000000	55.00
57.00	05700	CT SCAN	9,159,022	21,278,787	30,437,809	0.036715	0.000000	57.00
58.00	05800	MRI	2,880,465	12,230,613	15,111,078	0.049174	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	13,930,263	12,551,706	26,481,969	0.167000	0.000000	59.00
60.00	06000	LABORATORY	39,304,346	35,924,787	75,229,133	0.148211	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,560,671	616,922	3,177,593	0.208067	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	9,866,225	768,037	10,634,262	0.242356	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	11,719,884	1,729,743	13,449,627	0.323628	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	10,812,650	14,759,033	25,571,683	0.032401	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	382,556	1,488,679	1,871,235	0.062908	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21,642,821	25,294,596	46,937,417	0.165189	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,703,069	13,241,966	32,945,035	0.203776	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	64,540,246	21,661,060	86,201,306	0.159063	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,664,368	154,359	1,818,727	0.266271	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	1,124	799,212	800,336	0.216849	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	93,401	3,607,206	3,700,607	0.275821	0.000000	90.00
91.00	09100	EMERGENCY	17,028,070	29,472,997	46,501,067	0.111470	0.000000	91.00
91.01	09101	PARTIAL HOSPITALIZATION	3,175	1,200,894	1,204,069	0.447388	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,078,167	10,080,096	12,158,263	0.283486	0.000000	92.00
200.00		Subtotal (see instructions)	458,386,925	382,650,748	841,037,673			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	458,386,925	382,650,748	841,037,673			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.189562			50.00
51.00	05100	RECOVERY ROOM	0.092128			51.00
53.00	05300	ANESTHESIOLOGY	0.009385			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.170651			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.160644			55.00
57.00	05700	CT SCAN	0.036715			57.00
58.00	05800	MRI	0.049174			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.167000			59.00
60.00	06000	LABORATORY	0.148211			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.208067			63.00
65.00	06500	RESPIRATORY THERAPY	0.242356			65.00
66.00	06600	PHYSICAL THERAPY	0.323628			66.00
69.00	06900	ELECTROCARDIOLOGY	0.032401			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.062908			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.165189			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.203776			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.159063			73.00
74.00	07400	RENAL DIALYSIS	0.266271			74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000			76.00
76.97	07697	CARDIAC REHABILITATION	0.216849			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	0.275821			90.00
91.00	09100	EMERGENCY	0.111470			91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.447388			91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.283486			92.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
12/5/2019 9:25 am

				Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	43,030,170		43,030,170	18,496	43,048,666	30.00	
31.00	03100	INTENSIVE CARE UNIT	6,193,716		6,193,716	0	6,193,716	31.00	
40.00	04000	SUBPROVIDER - IPF	7,702,583		7,702,583	0	7,702,583	40.00	
41.00	04100	SUBPROVIDER - IRF	1,272,604		1,272,604	0	1,272,604	41.00	
43.00	04300	NURSERY	5,087,625		5,087,625	0	5,087,625	43.00	
44.00	04400	SKILLED NURSING FACILITY	6,341,850		6,341,850	0	6,341,850	44.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	24,358,846		24,358,846	0	24,358,846	50.00	
51.00	05100	RECOVERY ROOM	1,361,623		1,361,623	0	1,361,623	51.00	
53.00	05300	ANESTHESIOLOGY	252,345		252,345	0	252,345	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,764,118		7,764,118	0	7,764,118	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	3,267,517		3,267,517	0	3,267,517	55.00	
57.00	05700	CT SCAN	1,117,521		1,117,521	0	1,117,521	57.00	
58.00	05800	MRI	743,079		743,079	0	743,079	58.00	
59.00	05900	CARDIAC CATHETERIZATION	4,422,486		4,422,486	0	4,422,486	59.00	
60.00	06000	LABORATORY	11,149,817		11,149,817	0	11,149,817	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	661,152		661,152	0	661,152	63.00	
65.00	06500	RESPIRATORY THERAPY	2,577,272	0	2,577,272	0	2,577,272	65.00	
66.00	06600	PHYSICAL THERAPY	4,352,674	0	4,352,674	0	4,352,674	66.00	
69.00	06900	ELECTROCARDIOLOGY	828,548		828,548	0	828,548	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	117,715		117,715	0	117,715	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,753,525		7,753,525	0	7,753,525	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,713,398		6,713,398	0	6,713,398	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	13,711,430		13,711,430	0	13,711,430	73.00	
74.00	07400	RENAL DIALYSIS	484,275		484,275	0	484,275	74.00	
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0		0	0	0	76.00	
76.97	07697	CARDIAC REHABILITATION	173,552		173,552	0	173,552	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	1,020,704		1,020,704	0	1,020,704	90.00	
91.00	09100	EMERGENCY	5,183,472		5,183,472	0	5,183,472	91.00	
91.01	09101	PARTIAL HOSPITALIZATION	538,686		538,686	0	538,686	91.01	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,446,700		3,446,700	0	3,446,700	92.00	
200.00		Subtotal (see instructions)	171,629,003	0	171,629,003	18,496	171,647,499	200.00	
201.00		Less Observation Beds	3,446,700		3,446,700	0	3,446,700	201.00	
202.00		Total (see instructions)	168,182,303	0	168,182,303	18,496	168,200,799	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES					Provider CCN: 14-0224		Period: From 07/01/2018 To 06/30/2019		Worksheet C Part I Date/Time Prepared: 12/5/2019 9:25 am		
					Title XIX			Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio				
			Inpatient	Outpatient	Total (col. 6 + col. 7)						
			6.00	7.00	8.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	114,218,159		114,218,159					30.00	
31.00	03100	INTENSIVE CARE UNIT	14,193,669		14,193,669					31.00	
40.00	04000	SUBPROVIDER - IPF	10,929,596		10,929,596					40.00	
41.00	04100	SUBPROVIDER - IRF	1,026,037		1,026,037					41.00	
43.00	04300	NURSERY	22,925,150		22,925,150					43.00	
44.00	04400	SKILLED NURSING FACILITY	7,508,060		7,508,060					44.00	
ANCILLARY SERVICE COST CENTERS											
50.00	05000	OPERATING ROOM	37,770,095	90,730,559	128,500,654	0.189562	0.000000			50.00	
51.00	05100	RECOVERY ROOM	6,061,030	8,718,631	14,779,661	0.092128	0.000000			51.00	
53.00	05300	ANESTHESIOLOGY	8,333,226	18,555,027	26,888,253	0.009385	0.000000			53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,464,341	38,032,752	45,497,093	0.170651	0.000000			54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	587,039	19,753,086	20,340,125	0.160644	0.000000			55.00	
57.00	05700	CT SCAN	9,159,022	21,278,787	30,437,809	0.036715	0.000000			57.00	
58.00	05800	MRI	2,880,465	12,230,613	15,111,078	0.049174	0.000000			58.00	
59.00	05900	CARDIAC CATHETERIZATION	13,930,263	12,551,706	26,481,969	0.167000	0.000000			59.00	
60.00	06000	LABORATORY	39,304,346	35,924,787	75,229,133	0.148211	0.000000			60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000			62.30	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,560,671	616,922	3,177,593	0.208067	0.000000			63.00	
65.00	06500	RESPIRATORY THERAPY	9,866,225	768,037	10,634,262	0.242356	0.000000			65.00	
66.00	06600	PHYSICAL THERAPY	11,719,884	1,729,743	13,449,627	0.323628	0.000000			66.00	
69.00	06900	ELECTROCARDIOLOGY	10,812,650	14,759,033	25,571,683	0.032401	0.000000			69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	382,556	1,488,679	1,871,235	0.062908	0.000000			70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21,642,821	25,294,596	46,937,417	0.165189	0.000000			71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,703,069	13,241,966	32,945,035	0.203776	0.000000			72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	64,540,246	21,661,060	86,201,306	0.159063	0.000000			73.00	
74.00	07400	RENAL DIALYSIS	1,664,368	154,359	1,818,727	0.266271	0.000000			74.00	
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	0.000000			76.00	
76.97	07697	CARDIAC REHABILITATION	1,124	799,212	800,336	0.216849	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	93,401	3,607,206	3,700,607	0.275821	0.000000			90.00	
91.00	09100	EMERGENCY	17,028,070	29,472,997	46,501,067	0.111470	0.000000			91.00	
91.01	09101	PARTIAL HOSPITALIZATION	3,175	1,200,894	1,204,069	0.447388	0.000000			91.01	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,078,167	10,080,096	12,158,263	0.283486	0.000000			92.00	
200.00		Subtotal (see instructions)	458,386,925	382,650,748	841,037,673					200.00	
201.00		Less Observation Beds								201.00	
202.00		Total (see instructions)	458,386,925	382,650,748	841,037,673					202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
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
74.00	07400	RENAL DIALYSIS	0.000000			74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000			76.00
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
91.00	09100	EMERGENCY	0.000000			91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.000000			91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part I
Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Hospital Total Patient Days	PPS 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	10,181,623	0	10,181,623	36,333	280.23	30.00	
31.00	INTENSIVE CARE UNIT	1,372,672		1,372,672	2,357	582.38	31.00	
40.00	SUBPROVIDER - IPF	1,598,881	0	1,598,881	5,111	312.83	40.00	
41.00	SUBPROVIDER - IRF	441,662	0	441,662	384	1,150.16	41.00	
43.00	NURSERY	690,492		690,492	2,737	252.28	43.00	
44.00	SKILLED NURSING FACILITY	1,545,797		1,545,797	6,633	233.05	44.00	
200.00	Total (lines 30 through 199)	15,831,127		15,831,127	53,555		200.00	
Cost Center Description			Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
			6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	10,688	2,995,098					30.00
31.00	INTENSIVE CARE UNIT	1,339	779,807					31.00
40.00	SUBPROVIDER - IPF	0	0					40.00
41.00	SUBPROVIDER - IRF	219	251,885					41.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	4,308	1,003,979					44.00
200.00	Total (lines 30 through 199)	16,554	5,030,769					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part II
Date/Time Prepared:
12/5/2019 9:25 am

			Title XVIII		Hospital	PPS		
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,555,023	128,500,654	0.035447	11,402,161	404,172	50.00
51.00	05100	RECOVERY ROOM	245,331	14,779,661	0.016599	1,788,077	29,680	51.00
53.00	05300	ANESTHESIOLOGY	85,896	26,888,253	0.003195	2,243,704	7,169	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,844,971	45,497,093	0.040551	3,154,632	127,923	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	631,430	20,340,125	0.031044	312,691	9,707	55.00
57.00	05700	CT SCAN	200,238	30,437,809	0.006579	3,680,144	24,212	57.00
58.00	05800	MRI	121,666	15,111,078	0.008051	815,858	6,568	58.00
59.00	05900	CARDIAC CATHETERIZATION	949,861	26,481,969	0.035868	6,026,918	216,173	59.00
60.00	06000	LABORATORY	1,670,044	75,229,133	0.022199	13,636,071	302,707	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	64,798	3,177,593	0.020392	794,120	16,194	63.00
65.00	06500	RESPIRATORY THERAPY	418,579	10,634,262	0.039361	3,997,659	157,352	65.00
66.00	06600	PHYSICAL THERAPY	772,566	13,449,627	0.057441	1,908,867	109,647	66.00
69.00	06900	ELECTROCARDIOLOGY	97,781	25,571,683	0.003824	4,415,420	16,885	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	15,790	1,871,235	0.008438	150,919	1,273	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	797,217	46,937,417	0.016985	7,007,731	119,026	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	686,857	32,945,035	0.020849	6,589,183	137,378	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,606,437	86,201,306	0.018636	18,607,196	346,764	73.00
74.00	07400	RENAL DIALYSIS	47,222	1,818,727	0.025964	973,470	25,275	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	17,454	800,336	0.021808	1,124	25	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	129,122	3,700,607	0.034892	22,816	796	90.00
91.00	09100	EMERGENCY	539,316	46,501,067	0.011598	6,702,441	77,735	91.00
91.01	09101	PARTIAL HOSPITALIZATION	53,830	1,204,069	0.044707	2,700	121	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	815,193	12,158,263	0.067048	1,018,468	68,286	92.00
200.00	Total (lines 50 through 199)		16,366,622	670,237,002		95,252,370	2,205,068	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0224		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part III Date/Time Prepared: 12/5/2019 9:25 am	
					Title XVIII		Hospital		PPS	
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	41.00	
43.00	04300	NURSERY	0	0	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	44.00	
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	36,333	0.00	10,688	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	2,357	0.00	1,339	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	5,111	0.00	0	40.00		
41.00	04100	SUBPROVIDER - IRF	0	0	384	0.00	219	41.00		
43.00	04300	NURSERY	0	0	2,737	0.00	0	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	6,633	0.00	4,308	44.00		
200.00		Total (lines 30 through 199)	0	0	53,555		16,554	200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost						
			9.00	13.00						
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0	0						31.00
40.00	04000	SUBPROVIDER - IPF	0	0						40.00
41.00	04100	SUBPROVIDER - IRF	0	0						41.00
43.00	04300	NURSERY	0	0						43.00
44.00	04400	SKILLED NURSING FACILITY	0	0						44.00
200.00		Total (lines 30 through 199)	0	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019

Worksheet D
Part IV
Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	76.00
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
91.00	09100	EMERGENCY	0	0	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	312,385	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0224		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 12/5/2019 9:25 am	
			Title XVIII		Hospital		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	128,500,654	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	14,779,661	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	26,888,253	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	45,497,093	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	20,340,125	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	30,437,809	0.000000	57.00
58.00	05800	MRI	0	0	0	15,111,078	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	26,481,969	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	75,229,133	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	3,177,593	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,634,262	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	13,449,627	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	25,571,683	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,871,235	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	46,937,417	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	32,945,035	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	312,385	312,385	86,201,306	0.003624	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,818,727	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	800,336	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	3,700,607	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	46,501,067	0.000000	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	1,204,069	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	12,158,263	0.000000	92.00
200.00		Total (lines 50 through 199)	0	312,385	312,385	670,237,002		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019

Worksheet D
Part IV
Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description		Title XVIII			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	11,402,161	0	14,847,686	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	1,788,077	0	1,201,261	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	2,243,704	0	3,328,637	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	3,154,632	0	8,086,000	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	312,691	0	6,162,474	0	55.00
57.00	05700	CT SCAN	0.000000	3,680,144	0	5,771,431	0	57.00
58.00	05800	MRI	0.000000	815,858	0	2,582,475	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	6,026,918	0	5,021,325	0	59.00
60.00	06000	LABORATORY	0.000000	13,636,071	0	7,653,805	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	794,120	0	199,443	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	3,997,659	0	187,642	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,908,867	0	241,022	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	4,415,420	0	4,506,431	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	150,919	0	360,444	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	7,007,731	0	4,746,984	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	6,589,183	0	3,211,483	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.003624	18,607,196	67,432	4,960,376	17,976	73.00
74.00	07400	RENAL DIALYSIS	0.000000	973,470	0	108,975	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	1,124	0	357,244	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	22,816	0	962,100	0	90.00
91.00	09100	EMERGENCY	0.000000	6,702,441	0	5,927,306	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.000000	2,700	0	461,394	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,018,468	0	3,239,776	0	92.00
200.00		Total (lines 50 through 199)		95,252,370	67,432	84,125,714	17,976	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0224		Period: From 07/01/2018 To 06/30/2019	Worksheet D Part IV Date/Time Prepared: 12/5/2019 9:25 am
			Title XVIII		Hospital	PPS
Cost Center Description			PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
			21.00	24.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
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
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0		76.00
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
91.00	09100	EMERGENCY	0	0		91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Total (lines 50 through 199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part V
Date/Time Prepared:
12/5/2019 9:25 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.189562	14,847,686	0	0	2,814,557	50.00
51.00	05100	RECOVERY ROOM	0.092128	1,201,261	0	0	110,670	51.00
53.00	05300	ANESTHESIOLOGY	0.009385	3,328,637	0	0	31,239	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.170651	8,086,000	0	0	1,379,884	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.160644	6,162,474	0	0	989,964	55.00
57.00	05700	CT SCAN	0.036715	5,771,431	0	0	211,898	57.00
58.00	05800	MRI	0.049174	2,582,475	0	0	126,991	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.167000	5,021,325	0	0	838,561	59.00
60.00	06000	LABORATORY	0.148211	7,653,805	0	0	1,134,378	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.208067	199,443	0	0	41,498	63.00
65.00	06500	RESPIRATORY THERAPY	0.242356	187,642	0	0	45,476	65.00
66.00	06600	PHYSICAL THERAPY	0.323628	241,022	0	0	78,001	66.00
69.00	06900	ELECTROCARDIOLOGY	0.032401	4,506,431	0	0	146,013	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.062908	360,444	0	0	22,675	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.165189	4,746,984	0	0	784,150	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.203776	3,211,483	140,000	0	654,423	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.159063	4,960,376	606	32,606	789,012	73.00
74.00	07400	RENAL DIALYSIS	0.266271	108,975	0	0	29,017	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.216849	357,244	0	0	77,468	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	0.275821	962,100	0	0	265,367	90.00
91.00	09100	EMERGENCY	0.111470	5,927,306	0	0	660,717	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.447388	461,394	0	0	206,422	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.283486	3,239,776	0	0	918,431	92.00
200.00		Subtotal (see instructions)		84,125,714	140,606	32,606	12,356,812	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0		201.00
		Only Charges						
202.00		Net Charges (line 200 - line 201)		84,125,714	140,606	32,606	12,356,812	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part V
Date/Time Prepared:
12/5/2019 9:25 am

			Title XVIII		Hospital	PPS
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
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	28,529	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	96	5,186		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0		76.00
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
91.00	09100	EMERGENCY	0	0		91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	28,625	5,186		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	28,625	5,186		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS					Provider CCN: 14-0224 Component CCN: 14-T224		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part II Date/Time Prepared: 12/5/2019 9:25 am		
					Title XVIII		Subprovider - IRF		PPS		
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)				
			1.00	2.00	3.00	4.00	5.00				
	ANCILLARY SERVICE COST CENTERS										
50.00	05000	OPERATING ROOM	4,555,023	128,500,654	0.035447	0	0	50.00			
51.00	05100	RECOVERY ROOM	245,331	14,779,661	0.016599	0	0	51.00			
53.00	05300	ANESTHESIOLOGY	85,896	26,888,253	0.003195	0	0	53.00			
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,844,971	45,497,093	0.040551	10,146	411	54.00			
55.00	05500	RADIOLOGY-THERAPEUTIC	631,430	20,340,125	0.031044	0	0	55.00			
57.00	05700	CT SCAN	200,238	30,437,809	0.006579	9,453	62	57.00			
58.00	05800	MRI	121,666	15,111,078	0.008051	3,495	28	58.00			
59.00	05900	CARDIAC CATHETERIZATION	949,861	26,481,969	0.035868	0	0	59.00			
60.00	06000	LABORATORY	1,670,044	75,229,133	0.022199	88,231	1,959	60.00			
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30			
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	64,798	3,177,593	0.020392	78	2	63.00			
65.00	06500	RESPIRATORY THERAPY	418,579	10,634,262	0.039361	15,320	603	65.00			
66.00	06600	PHYSICAL THERAPY	772,566	13,449,627	0.057441	328,065	18,844	66.00			
69.00	06900	ELECTROCARDIOLOGY	97,781	25,571,683	0.003824	3,507	13	69.00			
70.00	07000	ELECTROENCEPHALOGRAPHY	15,790	1,871,235	0.008438	0	0	70.00			
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	797,217	46,937,417	0.016985	23,435	398	71.00			
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	686,857	32,945,035	0.020849	0	0	72.00			
73.00	07300	DRUGS CHARGED TO PATIENTS	1,606,437	86,201,306	0.018636	150,798	2,810	73.00			
74.00	07400	RENAL DIALYSIS	47,222	1,818,727	0.025964	15,276	397	74.00			
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0	0	76.00			
76.97	07697	CARDIAC REHABILITATION	17,454	800,336	0.021808	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	129,122	3,700,607	0.034892	0	0	90.00			
91.00	09100	EMERGENCY	539,316	46,501,067	0.011598	0	0	91.00			
91.01	09101	PARTIAL HOSPITALIZATION	53,830	1,204,069	0.044707	0	0	91.01			
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	12,158,263	0.000000	0	0	92.00			
200.00		Total (lines 50 through 199)	15,551,429	670,237,002		647,804	25,527	200.00			

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0224 Component CCN: 14-T224		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 12/5/2019 9:25 am	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
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	312,385	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER		0	0	0	0	0	76.00
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
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION		0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	312,385	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0224 Component CCN: 14-T224		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 12/5/2019 9:25 am	
			Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	128,500,654	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	14,779,661	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	26,888,253	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	45,497,093	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	20,340,125	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	30,437,809	0.000000	57.00
58.00	05800	MRI	0	0	0	15,111,078	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	26,481,969	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	75,229,133	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	3,177,593	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,634,262	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	13,449,627	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	25,571,683	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,871,235	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	46,937,417	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	32,945,035	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	312,385	312,385	86,201,306	0.003624	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,818,727	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	800,336	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	3,700,607	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	46,501,067	0.000000	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	1,204,069	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	12,158,263	0.000000	92.00
200.00		Total (lines 50 through 199)	0	312,385	312,385	670,237,002		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0224 Component CCN: 14-T224		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 12/5/2019 9:25 am	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	10,146	0	2,594	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	0	0	0	0	55.00
57.00	05700	CT SCAN		0.000000	9,453	0	0	0	57.00
58.00	05800	MRI		0.000000	3,495	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	88,231	0	318	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.000000	78	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0.000000	15,320	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	328,065	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	3,507	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	23,435	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.003624	150,798	546	1,241	4	73.00
74.00	07400	RENAL DIALYSIS		0.000000	15,276	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER		0.000000	0	0	0	0	76.00
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
91.00	09100	EMERGENCY		0.000000	0	0	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION		0.000000	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			647,804	546	4,153	4	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0224 Component CCN: 14-T224		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 12/5/2019 9:25 am	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost					
			21.00	24.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0					50.00
51.00	05100	RECOVERY ROOM	0	0					51.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0					55.00
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MRI	0	0					58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0					59.00
60.00	06000	LABORATORY	0	0					60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0					62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0					63.00
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
74.00	07400	RENAL DIALYSIS	0	0					74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0					76.00
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
91.00	09100	EMERGENCY	0	0					91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0					91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					92.00
200.00		Total (lines 50 through 199)	0	0					200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0224

Period:

Worksheet D

Component CCN: 14-T224

From 07/01/2018
To 06/30/2019Part V
Date/Time Prepared:
12/5/2019 9:25 am

Title XVIII

Subprovider -
IRF

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	0.189562	0	0	0	0 50.00
51.00	05100 RECOVERY ROOM	0.092128	0	0	0	0 51.00
53.00	05300 ANESTHESIOLOGY	0.009385	0	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.170651	2,594	0	0	443 54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.160644	0	0	0	0 55.00
57.00	05700 CT SCAN	0.036715	0	0	0	0 57.00
58.00	05800 MRI	0.049174	0	0	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.167000	0	0	0	0 59.00
60.00	06000 LABORATORY	0.148211	318	0	0	47 60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0 62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.208067	0	0	0	0 63.00
65.00	06500 RESPIRATORY THERAPY	0.242356	0	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.323628	0	0	0	0 66.00
69.00	06900 ELECTROCARDIOLOGY	0.032401	0	0	0	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.062908	0	0	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.165189	0	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.203776	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.159063	1,241	0	0	197 73.00
74.00	07400 RENAL DIALYSIS	0.266271	0	0	0	0 74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0 76.00
76.97	07697 CARDIAC REHABILITATION	0.216849	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	0.275821	0	0	0	0 90.00
91.00	09100 EMERGENCY	0.111470	0	0	0	0 91.00
91.01	09101 PARTIAL HOSPITALIZATION	0.447388	0	0	0	0 91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.283486	0	0	0	0 92.00
200.00	Subtotal (see instructions)		4,153	0	0	687 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 - line 201)		4,153	0	0	687 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0224

Period:

Worksheet D

Component CCN: 14-T224

From 07/01/2018
To 06/30/2019Part V
Date/Time Prepared:
12/5/2019 9:25 am

Title XVIII

Subprovider -
IRF

PPS

Cost Center Description			Costs			
			Cost	Cost		
			Reimbursed	Reimbursed		
			Services Subject To Ded. & Coins. (see inst.)	Services Not Subject To Ded. & Coins. (see inst.)		
		6.00	7.00			
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00	
51.00	05100	RECOVERY ROOM	0	0	51.00	
53.00	05300	ANESTHESIOLOGY	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00	
57.00	05700	CT SCAN	0	0	57.00	
58.00	05800	MRI	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00	
60.00	06000	LABORATORY	0	0	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00	
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	
74.00	07400	RENAL DIALYSIS	0	0	74.00	
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	76.00	
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	
91.00	09100	EMERGENCY	0	0	91.00	
91.01	09101	PARTIAL HOSPITALIZATION	0	0	91.01	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00	
200.00		Subtotal (see instructions)	0	0	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00	
202.00		Net Charges (line 200 - line 201)	0	0	202.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0224 Component CCN: 14-5568		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 12/5/2019 9:25 am	
				Title XVIII		Skilled Nursing Facility		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
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
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	312,385	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER		0	0	0	0	0	76.00
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
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION		0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	312,385	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0224 Component CCN: 14-5568		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 12/5/2019 9:25 am	
			Title XVIII		Skilled Nursing Facility		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	128,500,654	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	14,779,661	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	26,888,253	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	45,497,093	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	20,340,125	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	30,437,809	0.000000	57.00
58.00	05800	MRI	0	0	0	15,111,078	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	26,481,969	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	75,229,133	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	3,177,593	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,634,262	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	13,449,627	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	25,571,683	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,871,235	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	46,937,417	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	32,945,035	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	312,385	312,385	86,201,306	0.003624	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,818,727	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	800,336	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	3,700,607	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	46,501,067	0.000000	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	1,204,069	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	12,158,263	0.000000	92.00
200.00		Total (lines 50 through 199)	0	312,385	312,385	670,237,002		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0224 Component CCN: 14-5568		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 12/5/2019 9:25 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	145,411	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	406	0	0	0	55.00
57.00	05700	CT SCAN		0.000000	3,151	0	0	0	57.00
58.00	05800	MRI		0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	1,704	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	1,035,697	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.000000	5,381	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0.000000	229,878	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	4,558,995	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	73,963	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	2,617	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	364,284	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.003624	2,309,236	8,369	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER		0.000000	0	0	0	0	76.00
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
91.00	09100	EMERGENCY		0.000000	0	0	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION		0.000000	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	1,417	0	0	0	92.00
200.00		Total (lines 50 through 199)			8,732,140	8,369	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0224 Component CCN: 14-5568		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 12/5/2019 9:25 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost				
				21.00	24.00				
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0				50.00	
51.00	05100	RECOVERY ROOM	0	0				51.00	
53.00	05300	ANESTHESIOLOGY	0	0				53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0				54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0				55.00	
57.00	05700	CT SCAN	0	0				57.00	
58.00	05800	MRI	0	0				58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0				59.00	
60.00	06000	LABORATORY	0	0				60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62.30	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0				63.00	
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	
74.00	07400	RENAL DIALYSIS	0	0				74.00	
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0				76.00	
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	
91.00	09100	EMERGENCY	0	0				91.00	
91.01	09101	PARTIAL HOSPITALIZATION	0	0				91.01	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00	
200.00		Total (lines 50 through 199)	0	0				200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0224

Period:

Worksheet D

Component CCN: 14-5568

From 07/01/2018
To 06/30/2019Part V
Date/Time Prepared:
12/5/2019 9:25 am

Title XVIII

Skilled Nursing
Facility

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	0.189562	0	0	0	0 50.00
51.00	05100 RECOVERY ROOM	0.092128	0	0	0	0 51.00
53.00	05300 ANESTHESIOLOGY	0.009385	0	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.170651	0	0	0	0 54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.160644	0	0	0	0 55.00
57.00	05700 CT SCAN	0.036715	0	0	0	0 57.00
58.00	05800 MRI	0.049174	0	0	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.167000	0	0	0	0 59.00
60.00	06000 LABORATORY	0.148211	0	0	0	0 60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0 62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.208067	0	0	0	0 63.00
65.00	06500 RESPIRATORY THERAPY	0.242356	0	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.323628	0	0	0	0 66.00
69.00	06900 ELECTROCARDIOLOGY	0.032401	0	0	0	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.062908	0	0	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.165189	0	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.203776	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.159063	0	0	6,505	0 73.00
74.00	07400 RENAL DIALYSIS	0.266271	0	0	0	0 74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0 76.00
76.97	07697 CARDIAC REHABILITATION	0.216849	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	0.275821	0	0	0	0 90.00
91.00	09100 EMERGENCY	0.111470	0	0	0	0 91.00
91.01	09101 PARTIAL HOSPITALIZATION	0.447388	0	0	0	0 91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.283486	0	0	0	0 92.00
200.00	Subtotal (see instructions)		0	0	6,505	0 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 - line 201)		0	0	6,505	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0224 Component CCN: 14-5568		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part V Date/Time Prepared: 12/5/2019 9:25 am		
			Title XVIII		Skilled Nursing Facility		PPS		
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0					50.00
51.00	05100	RECOVERY ROOM	0	0					51.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0					55.00
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MRI	0	0					58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0					59.00
60.00	06000	LABORATORY	0	0					60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0					62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0					63.00
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	1,035					73.00
74.00	07400	RENAL DIALYSIS	0	0					74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0					76.00
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
91.00	09100	EMERGENCY	0	0					91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0					91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					92.00
200.00		Subtotal (see instructions)	0	1,035					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	1,035					202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0224	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 12/5/2019 9:25 am
		Title XVIII	Hospital	PPS
Cost Center Description				
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		36,333	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		36,333	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)		33,424	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		10,688	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)		43,048,666	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)		43,048,666	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)		43,048,666	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,184.84	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		12,663,570	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)		12,663,570	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019

Worksheet D-1

Date/Time Prepared:
12/5/2019 9:25 am

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	6,193,716	2,357	2,627.80	1,339	3,518,624		43.00
44.00	CORONARY CARE UNIT							44.00
45.00	BURN INTENSIVE CARE UNIT							45.00
46.00	SURGICAL INTENSIVE CARE UNIT							46.00
47.00	OTHER SPECIAL CARE (SPECIFY)							47.00
	Cost Center Description							
						1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					14,805,759		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					30,987,953		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)					3,774,905		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,272,500		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					6,047,405		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					24,940,548		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)					2,909		87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,184.84		88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,446,700		89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019

Worksheet D-1

Date/Time Prepared:
12/5/2019 9:25 am

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	10,181,623	43,048,666	0.236514	3,446,700	815,193	90.00
91.00 Nursing School cost	0	43,048,666	0.000000	3,446,700	0	91.00
92.00 Allied health cost	0	43,048,666	0.000000	3,446,700	0	92.00
93.00 All other Medical Education	0	43,048,666	0.000000	3,446,700	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0224 Component CCN: 14-T224	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 12/5/2019 9:25 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		384	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		384	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)		384	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)		219	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)		1,272,604	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)		1,272,604	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)		1,272,604	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)		3,314.07	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		725,781	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)		725,781	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0224 Component CCN: 14-T224	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 12/5/2019 9:25 am	
				Title XVIII	Subprovider - IRF	PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					157,266	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					883,047	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)					251,885	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					26,073	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					277,958	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					605,089	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0224 Component CCN: 14-T224		Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 12/5/2019 9:25 am	
		Title XVIII		Subprovider - IRF	PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	441,662	1,272,604	0.347054	0	0 90.00
91.00	Nursing School cost	0	1,272,604	0.000000	0	0 91.00
92.00	Allied health cost	0	1,272,604	0.000000	0	0 92.00
93.00	All other Medical Education	0	1,272,604	0.000000	0	0 93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0224 Component CCN: 14-5568	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 12/5/2019 9:25 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,633	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,633	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)		6,633	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)		4,308	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)		6,341,850	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)		6,341,850	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)		6,341,850	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)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0224 Component CCN: 14-5568	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 12/5/2019 9:25 am	
				Title XVIII		Skilled Nursing Facility	PPS
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						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)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						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						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						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)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						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)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						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)						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)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						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)					6,341,850	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					956.11	71.00
72.00	Program routine service cost (line 9 x line 71)					4,118,922	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					4,118,922	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)					0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00	Inpatient routine service cost per diem limitation					0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)					4,118,922	83.00
84.00	Program inpatient ancillary services (see instructions)					2,141,486	84.00
85.00	Utilization review - physician compensation (see instructions)					0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					6,260,408	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0224 Component CCN: 14-5568		Period: From 07/01/2018 To 06/30/2019		Worksheet D-1 Date/Time Prepared: 12/5/2019 9:25 am
			Title XVIII		Skilled Nursing Facility		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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0224	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 12/5/2019 9:25 am
		Title XIX	Hospital	Cost
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)		36,333	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		36,333	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)		33,424	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)		528	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)		2,737	15.00
16.00	Nursery days (title V or XIX only)		1,114	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)		43,030,170	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)		43,030,170	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)		43,030,170	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,184.33	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		625,326	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)		625,326	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019

Worksheet D-1

Date/Time Prepared:
12/5/2019 9:25 am

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)	5,087,625	2,737	1,858.83	1,114	2,070,737	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	6,193,716	2,357	2,627.80	25	65,695	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,761,758	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)					2,909	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,184.33	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,445,216	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019

Worksheet D-1

Date/Time Prepared:
12/5/2019 9:25 am

		Title XIX		Hospital	Cost	
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	10,181,623	43,030,170	0.236616	3,445,216	815,193	90.00
91.00 Nursing School cost	0	43,030,170	0.000000	3,445,216	0	91.00
92.00 Allied health cost	0	43,030,170	0.000000	3,445,216	0	92.00
93.00 All other Medical Education	0	43,030,170	0.000000	3,445,216	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0224 Component CCN: 14-T224	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 12/5/2019 9:25 am
		Title XIX	Subprovider - IRF	Cost
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)			384 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			384 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)			384 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)			5 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)			2,737 15.00
16.00	Nursery days (title V or XIX only)			1,114 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)			1,272,604 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)			1,272,604 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)			1,272,604 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)			3,314.07 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			16,570 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)			16,570 41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0224 Component CCN: 14-T224	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 12/5/2019 9:25 am	
				Title XIX		Subprovider - IRF	Cost
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					16,570	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)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0224

Period:

Worksheet D-1

Component CCN: 14-T224

From 07/01/2018
To 06/30/2019Date/Time Prepared:
12/5/2019 9:25 am

Title XIX

Subprovider -
IRF

Cost

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	441,662	1,272,604	0.347054	0	0	90.00
91.00	Nursing School cost	0	1,272,604	0.000000	0	0	91.00
92.00	Allied health cost	0	1,272,604	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,272,604	0.000000	0	0	93.00

Health Financial Systems		PRESENCE SAINT JOSEPH HOSP-CHICAGO		In Lieu of Form CMS-2552-10	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0224	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 12/5/2019 9:25 am
			Title XVIII	Hospital	PPS
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		33,844,182	30.00
31.00	03100	INTENSIVE CARE UNIT		6,648,391	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.189562	11,402,161	50.00
51.00	05100	RECOVERY ROOM	0.092128	1,788,077	51.00
53.00	05300	ANESTHESIOLOGY	0.009385	2,243,704	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.170651	3,154,632	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.160644	312,691	55.00
57.00	05700	CT SCAN	0.036715	3,680,144	57.00
58.00	05800	MRI	0.049174	815,858	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.167000	6,026,918	59.00
60.00	06000	LABORATORY	0.148211	13,636,071	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.208067	794,120	63.00
65.00	06500	RESPIRATORY THERAPY	0.242356	3,997,659	65.00
66.00	06600	PHYSICAL THERAPY	0.323628	1,908,867	66.00
69.00	06900	ELECTROCARDIOLOGY	0.032401	4,415,420	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.062908	150,919	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.165189	7,007,731	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.203776	6,589,183	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.159063	18,607,196	73.00
74.00	07400	RENAL DIALYSIS	0.266271	973,470	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.216849	1,124	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.275821	22,816	90.00
91.00	09100	EMERGENCY	0.111470	6,702,441	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.447388	2,700	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.283486	1,018,468	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		95,252,370	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)		95,252,370	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0224 Component CCN: 14-T224	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 12/5/2019 9:25 am	
			Title XVIII	Subprovider - IRF	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		581,745		41.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.189562	0	0	50.00
51.00	05100	RECOVERY ROOM	0.092128	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.009385	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.170651	10,146	1,731	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.160644	0	0	55.00
57.00	05700	CT SCAN	0.036715	9,453	347	57.00
58.00	05800	MRI	0.049174	3,495	172	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.167000	0	0	59.00
60.00	06000	LABORATORY	0.148211	88,231	13,077	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.208067	78	16	63.00
65.00	06500	RESPIRATORY THERAPY	0.242356	15,320	3,713	65.00
66.00	06600	PHYSICAL THERAPY	0.323628	328,065	106,171	66.00
69.00	06900	ELECTROCARDIOLOGY	0.032401	3,507	114	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.062908	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.165189	23,435	3,871	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.203776	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.159063	150,798	23,986	73.00
74.00	07400	RENAL DIALYSIS	0.266271	15,276	4,068	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.216849	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	0.275821	0	0	90.00
91.00	09100	EMERGENCY	0.111470	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.447388	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.283486	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		647,804	157,266	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)		647,804		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0224 Component CCN: 14-5568	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 12/5/2019 9:25 am	
		Title XVIII	Skilled Nursing Facility	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		453		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.189562	0	0	50.00
51.00	05100 RECOVERY ROOM	0.092128	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.009385	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.170651	145,411	24,815	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.160644	406	65	55.00
57.00	05700 CT SCAN	0.036715	3,151	116	57.00
58.00	05800 MRI	0.049174	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.167000	1,704	285	59.00
60.00	06000 LABORATORY	0.148211	1,035,697	153,502	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.208067	5,381	1,120	63.00
65.00	06500 RESPIRATORY THERAPY	0.242356	229,878	55,712	65.00
66.00	06600 PHYSICAL THERAPY	0.323628	4,558,995	1,475,418	66.00
69.00	06900 ELECTROCARDIOLOGY	0.032401	73,963	2,396	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.062908	2,617	165	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.165189	364,284	60,176	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.203776	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.159063	2,309,236	367,314	73.00
74.00	07400 RENAL DIALYSIS	0.266271	0	0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.216849	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	0.275821	0	0	90.00
91.00	09100 EMERGENCY	0.111470	0	0	91.00
91.01	09101 PARTIAL HOSPITALIZATION	0.447388	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.283486	1,417	402	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		8,732,140	2,141,486	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)		8,732,140		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0224	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prepared: 12/5/2019 9:25 am	
		Title XVIII	Hospital	PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			5,416,248	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			14,952,795	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)			278,164	2.00
2.01	Outlier reconciliation amount			0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)			0	2.02
3.00	Managed Care Simulated Payments			6,392,771	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			228.73	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)	or		139.15	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)			22.76	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			0.64	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).			-15.00	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)			7.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)			107.75	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			103.77	10.00
11.00	FTE count for residents in dental and podiatric programs.			15.00	11.00
12.00	Current year allowable FTE (see instructions)			118.77	12.00
13.00	Total allowable FTE count for the prior year.			117.73	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.			121.28	14.00
15.00	Sum of lines 12 through 14 divided by 3.			119.26	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			119.26	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.521401	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.446772	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.446772	21.00
22.00	IME payment adjustment (see instructions)			4,436,744	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			1,392,461	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)			-3.98	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)			4,436,744	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			1,392,461	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			6.97	30.00
31.00	Percentage of Medicaid patient days (see instructions)			23.42	31.00
32.00	Sum of lines 30 and 31			30.39	32.00
33.00	Allowable disproportionate share percentage (see instructions)			12.06	33.00
34.00	Disproportionate share adjustment (see instructions)			614,127	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0224	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prepared: 12/5/2019 9:25 am
		Title XVIII	Hospital	PPS
			Prior to 10/1	On/After 10/1
			1.00	2.00
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)		0	0
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,860,774	1,691,203	
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	469,017	1,264,927	
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,733,944		
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	
			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
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		
47.00	Subtotal (see instructions)	27,432,022		
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0		
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		28,824,483	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,524,202	
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		4,445,439	
53.00	Nursing and Allied Health Managed Care payment		45,186	
54.00	Special add-on payments for new technologies		0	
54.01	Islet isolation add-on payment		0	
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		67,432	
59.00	Total (sum of amounts on lines 49 through 58)		35,906,742	
60.00	Primary payer payments		24,990	
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		35,881,752	
62.00	Deductibles billed to program beneficiaries		2,292,656	
63.00	Coinsurance billed to program beneficiaries		84,225	
64.00	Allowable bad debts (see instructions)		847,684	
65.00	Adjusted reimbursable bad debts (see instructions)		550,995	
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		668,039	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		34,055,866	
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	
70.87	Demonstration payment adjustment amount before sequestration		0	
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	
70.92	Bundled Model 1 discount amount (see instructions)		0	
70.93	HVBP payment adjustment amount (see instructions)		82,257	
70.94	HRR adjustment amount (see instructions)		-187,456	
70.95	Recovery of accelerated depreciation		0	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0224	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prepared: 12/5/2019 9:25 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96	
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97	
70.98	Low Volume Payment-3		0	70.98	
70.99	HAC adjustment amount (see instructions)		0	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		33,950,667	71.00	
71.01	Sequestration adjustment (see instructions)		679,013	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
72.00	Interim payments		32,803,163	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)		468,491	74.00	
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		526,255	75.00	
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00	
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00	
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00	
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00	
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00	
95.00	Time value of money for operating expenses (see instructions)		0	95.00	
96.00	Time value of money for capital related expenses (see instructions)		0	96.00	
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	100.00	
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00	
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00	
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00	
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00	
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00	
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00	
202.00	Medicare discharges (see instructions)			202.00	
203.00	Case-mix adjustment factor (see instructions)			203.00	
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount			204.00	
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00	
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00	
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00	
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00	
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00	
210.00	Reserved for future use			210.00	
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00	
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00	
213.00	Low-volume adjustment (see instructions)			213.00	
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00	

CALCULATION OF DSH PAYMENT PERCENTAGE

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019

Worksheet DSH

Date/Time Prepared:
12/5/2019 9:25 am

		Title XVIII		Hospital		PPS	
		Original .mcrcx Values	Adjusted .mcrcx Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	6.97	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	23.42	0.00			23.42	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	30.39	0.00			23.42	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	Urban				Urban	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	228.73	0.00			228.73	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	12.06	0.00			8.54	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	Yes				No	9.00
10.00	S-2, Line 45	Yes				Yes	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	6.97	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	Yes				Yes	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	4.89	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	0	0			0	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	3,506	0			3,506	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	526	0			526	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	4,829	0			4,829	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	321	0			321	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	9,182	0			9,182	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	38,518	0			38,518	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	686	0			686	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	39,204	0			39,204	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	23.42	0.00			23.42	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE			Provider CCN: 14-0224		Period: From 07/01/2018 To 06/30/2019		Worksheet DSH Date/Time Prepared: 12/5/2019 9:25 am	
			Title XVIII		Hospital		PPS	
			Original .mcrx Values		Adjusted .mcax Values		Revised	
			Condition	Percentage	Condition	Percentage	Condition	
			1.00	2.00	3.00	4.00	5.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE								
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	14.29			0.00	True	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00			0.00	False	29.00
30.00	Line 28 or 29 as applicable		14.29			0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		14.29			0.00		31.00
			Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
			1.00	2.00	3.00	4.00	5.00	
DETERMINATION OF PROVIDER TYPE								
32.00	Does the hospital qualify under the Pickle ammendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False					False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False					False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False					False	34.00
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False					False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban					Urban	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 14-0224	Period: From 07/01/2018 To 06/30/2019	Worksheet DSH Date/Time Prepared: 12/5/2019 9:25 am
		Title XVIII	Hospital	PPS
		Revised Percentage 6.00		
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE				
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	8.54	28.00	
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	0.00	29.00	
30.00	Line 28 or 29 as applicable	8.54	30.00	
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	8.54	31.00	

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
12/5/2019 9:25 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	5,416,248	0	5,416,248		5,416,248
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	14,952,795	0		14,952,795	14,952,795
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00	278,164	0	48,572	229,592	278,164
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	6,392,771	0	1,446,923	4,945,849	6,392,772
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.446772	0.446772	0.446772	0.446772	
6.00	IME payment adjustment (see instructions)	22.00	4,436,744	0	1,179,756	3,256,988	4,436,744
6.01	IME payment adjustment for managed care (see instructions)	22.01	1,392,461	0	0	1,392,461	1,392,461
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	4,436,744	0	1,179,756	3,256,988	4,436,744
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	1,392,461	0	0	1,392,461	1,392,461
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1206	0.1206	0.1206	0.1206	
11.00	Disproportionate share adjustment (see instructions)	34.00	614,127	0	163,300	450,827	614,127
11.01	Uncompensated care payments	36.00	1,733,944	0	2,560,008	0	2,560,008
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	27,432,022	0	9,367,884	18,064,138	27,432,022
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	28,824,483	0	9,367,884	19,456,599	28,824,483
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,524,202	0	669,278	1,854,924	2,524,202
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0
17.01	Net organ acquisition 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	10,037,162	21,311,523	31,348,685

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
12/5/2019 9:25 am

				Title XVIII		Hospital	PPS	
		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	1,657,603	0	441,127	1,216,476	1,657,603	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	97,471	0	23,469	74,002	97,471	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.4006	0.4006	0.4006	0.4006		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	664,036	0	176,715	487,321	664,036	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0634	0.0634	0.0634	0.0634		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	105,092	0	27,967	77,125	105,092	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,524,202	0	669,278	1,854,924	2,524,202	26.00
		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		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
12/5/2019 9:25 am

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	5,416,248	5,416,248		5,416,248	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	14,952,795		14,952,795	14,952,795	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	278,164	48,572	229,592	278,164	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	6,392,771	1,446,923	4,945,849	6,392,772	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.446772	0.446772	0.446772		5.00
6.00	IME payment adjustment (see instructions)	22.00	4,436,744	1,179,756	3,256,988	4,436,744	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	1,392,461	315,166	1,077,295	1,392,461	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	4,436,744	1,179,756	3,256,988	4,436,744	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	1,392,461	315,166	1,077,295	1,392,461	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1206	0.1206	0.1206		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	614,127	163,300	450,827	614,127	11.00
11.01	Uncompensated care payments	36.00	1,733,944	469,017	1,264,927	1,733,944	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	27,432,022	7,276,893	20,155,129	27,432,022	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	28,824,483	7,592,059	21,232,424	28,824,483	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,524,202	669,278	1,854,924	2,524,202	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			8,261,337	23,087,348	31,348,685	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
12/5/2019 9:25 am

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,657,603	441,127	1,216,476	1,657,603	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	97,471	23,469	74,002	97,471	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	0.4006	0.4006	0.4006		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	664,036	176,715	487,321	664,036	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0634	0.0634	0.0634		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	105,092	27,967	77,125	105,092	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,524,202	669,278	1,854,924	2,524,202	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	82,257	44,972	37,285	82,257	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	-187,456	-69,328	-118,128	-187,456	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: 14-0224	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 12/5/2019 9:25 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		33,811	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		12,338,836	2.00
3.00	OPPS payments		10,560,075	3.00
4.00	Outlier payment (see instructions)		92,719	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		17,976	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		33,811	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		173,212	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)		173,212	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)		173,212	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		139,401	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)		33,811	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		10,670,770	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		28,000	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,095,688	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		8,580,893	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		1,435,254	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)		10,016,147	30.00
31.00	Primary payer payments		20	31.00
32.00	Subtotal (line 30 minus line 31)		10,016,127	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)		522,683	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		339,744	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		421,083	36.00
37.00	Subtotal (see instructions)		10,355,871	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		10,355,871	40.00
40.01	Sequestration adjustment (see instructions)		207,117	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		9,856,317	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		292,437	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: 14-0224	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 12/5/2019 9:25 am
	Title XVIII	Hospital	PPS
			Overrides
			1.00
WORKSHEET OVERRIDE VALUES			
112.00	Override of Ancillary service charges (line 12)		0112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0224 Component CCN: 14-T224	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 12/5/2019 9:25 am
		Title XVIII	Subprovider - IRF	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)		683	2.00
3.00	OPPS payments		236	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		4	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)		240	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)		47	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)		193	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)		193	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		193	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)		193	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)		193	40.00
40.01	Sequestration adjustment (see instructions)		4	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		185	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		4	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: 14-0224 Component CCN: 14-T224	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 12/5/2019 9:25 am
		Title XVIII	Subprovider - IRF	PPS
				Overrides
				1.00
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)			0112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0224 Component CCN: 14-5568	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 12/5/2019 9:25 am
		Title XVIII	Skilled Nursing Facility	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		1,035	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
4.01	Outlier reconciliation amount (see instructions)			4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			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)		1,035	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		6,505	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		6,505	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)		6,505	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		5,470	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)		1,035	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)		0	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)			26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		1,035	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)		1,035	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,035	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)		1,035	37.00
38.00	MSP-LCC reconciliation amount from PS&R			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)		1,035	40.00
40.01	Sequestration adjustment (see instructions)		21	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		1,658	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-644	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)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0224 Component CCN: 14-5568	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 12/5/2019 9:25 am
		Title XVIII	Skilled Nursing Facility	PPS
				Overrides
				1.00
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)			0112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet E-1
Part I
Date/Time Prepared:
12/5/2019 9:25 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		27,717,618		8,391,530	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		5,348,116		1,476,283	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	02/14/2019	262,571	02/14/2019	11,496	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)		-262,571		-11,496	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)		32,803,163		9,856,317	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		468,491		292,437	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		33,271,654		10,148,754	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: 14-0224

Period:

Worksheet E-1

Component CCN: 14-T224

From 07/01/2018
To 06/30/2019Part I
Date/Time Prepared:
12/5/2019 9:25 am

Title XVIII

Subprovider -
IRF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					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		425,234		185	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)		0		0	3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	08/02/2016	19,329		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)		-19,329		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)		405,905		185	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		12,459		4	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		418,364		189	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: 14-0224 Component CCN: 14-5568		Period: From 07/01/2018 To 06/30/2019		Worksheet E-1 Part I Date/Time Prepared: 12/5/2019 9:25 am	
		Title XVIII		Skilled Nursing Facility		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider						1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		2,261,600		1,658		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,261,600		1,658		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		9,215		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		644		6.02
7.00	Total Medicare program liability (see instructions)		2,270,815		1,014		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: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet E-1
Part II
Date/Time Prepared:
12/5/2019 9:25 am

		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0224 Component CCN: 14-T224	Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part III Date/Time Prepared: 12/5/2019 9:25 am
		Title XVIII	Subprovider - IRF	PPS
		1.00		
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)	399,400 1.00		
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0489 2.00		
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	19,690 3.00		
4.00	Outlier Payments	11,771 4.00		
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00 5.00		
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00 5.01		
6.00	New Teaching program adjustment. (see instructions)	0.00 6.00		
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00 7.00		
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00 8.00		
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00 9.00		
10.00	Average Daily Census (see instructions)	1.052055 10.00		
11.00	Teaching Adjustment Factor (see instructions)	0.000000 11.00		
12.00	Teaching Adjustment (see instructions)	0 12.00		
13.00	Total PPS Payment (see instructions)	430,861 13.00		
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0 14.00		
15.00	Organ acquisition (DO NOT USE THIS LINE)	0 15.00		
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0 16.00		
17.00	Subtotal (see instructions)	430,861 17.00		
18.00	Primary payer payments	0 18.00		
19.00	Subtotal (line 17 less line 18).	430,861 19.00		
20.00	Deductibles	1,340 20.00		
21.00	Subtotal (line 19 minus line 20)	429,521 21.00		
22.00	Coinsurance	4,020 22.00		
23.00	Subtotal (line 21 minus line 22)	425,501 23.00		
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	1,316 24.00		
25.00	Adjusted reimbursable bad debts (see instructions)	855 25.00		
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0 26.00		
27.00	Subtotal (sum of lines 23 and 25)	426,356 27.00		
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0 28.00		
29.00	Other pass through costs (see instructions)	546 29.00		
30.00	Outlier payments reconciliation	0 30.00		
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0 31.00		
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0 31.50		
31.99	Demonstration payment adjustment amount before sequestration	0 31.99		
32.00	Total amount payable to the provider (see instructions)	426,902 32.00		
32.01	Sequestration adjustment (see instructions)	8,538 32.01		
32.02	Demonstration payment adjustment amount after sequestration	0 32.02		
33.00	Interim payments	405,905 33.00		
34.00	Tentative settlement (for contractor use only)	0 34.00		
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	12,459 35.00		
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0 36.00		
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	11,771 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: 14-0224 Component CCN: 14-5568	Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part VI Date/Time Prepared: 12/5/2019 9:25 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES			
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)			
1.00	Resource Utilization Group Payment (RUGS)			2,409,768 1.00
2.00	Routine service other pass through costs			0 2.00
3.00	Ancillary service other pass through costs			8,369 3.00
4.00	Subtotal (sum of lines 1 through 3)			2,418,137 4.00
	COMPUTATION OF NET COST OF COVERED SERVICES			
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible			0 6.00
7.00	Coinsurance			102,013 7.00
8.00	Allowable bad debts (see instructions)			1,590 8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0 9.00
10.00	Adjusted reimbursable bad debts (see instructions)			1,034 10.00
11.00	Utilization review			0 11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)			2,317,158 12.00
13.00	Inpatient primary payer payments			0 13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 14.50
14.99	Demonstration payment adjustment amount before sequestration			0 14.99
15.00	Subtotal (see instructions)			2,317,158 15.00
15.01	Sequestration adjustment (see instructions)			46,343 15.01
15.02	Demonstration payment adjustment amount after sequestration			0 15.02
16.00	Interim payments			2,261,600 16.00
17.00	Tentative settlement (for contractor use only)			0 17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)			9,215 18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2			0 19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0224	Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part VII Date/Time Prepared: 12/5/2019 9:25 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		2,761,758		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		2,761,758	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		2,761,758	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		13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		2,761,758	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	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)		2,761,758	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	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00
OVERRIDES					
109.00	Override Ancillary service charges (line 9)		0	0	109.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0224 Component CCN: 14-T224	Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part VII Date/Time Prepared: 12/5/2019 9:25 am	
		Title XIX	Subprovider - IRF	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		16,570		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)		16,570	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)		16,570	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)		16,570	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0		28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		16,570	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		32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00
OVERRIDES					
109.00	Override Ancillary service charges (line 9)		0	0	109.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0224	Period: From 07/01/2018 To 06/30/2019	Worksheet E-4 Date/Time Prepared: 12/5/2019 9:25 am	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			142.44	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			23.61	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)			1.79	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))			-18.00	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)			7.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			106.04	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			103.77	6.00
7.00	Enter the lesser of line 5 or line 6			103.77	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.	88.20	14.53	102.73	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.	88.20	14.53	102.73	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		14.50		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	88.20	29.03		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	89.09	27.51		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	94.25	25.69		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	90.51	27.41		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	90.51	27.41		17.00
18.00	Per resident amount	137,350.62	132,391.54		18.00
19.00	Approved amount for resident costs	12,431,605	3,628,852	16,060,457	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)			16,060,457	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	12,246	3,632		26.00
27.00	Total Inpatient Days (see instructions)	41,962	41,962		27.00
28.00	Ratio of inpatient days to total inpatient days	0.291835	0.086555		28.00
29.00	Program direct GME amount	4,687,003	1,390,113		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		196,423		30.00
31.00	Net Program direct GME amount			5,880,693	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0224	Period: From 07/01/2018 To 06/30/2019	Worksheet E-4 Date/Time Prepared: 12/5/2019 9:25 am
		Title XVIII	Hospital	PPS
			1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)			
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		1,818,727	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)		38,408,059	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)		24,990	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		38,383,069	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		12,392,345	42.00
43.00	Primary payer payments (see instructions)		20	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		12,392,325	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		50,775,394	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.755938	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.244062	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		5,880,693	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		4,445,439	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		1,435,254	50.00

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

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019

Worksheet G

Date/Time Prepared:
12/5/2019 9:25 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	32,777	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	82,287,373	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-55,667,451	0	0	0	6.00
7.00	Inventory	4,816,819	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	551	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)	31,470,069	0	0	0	11.00
FIXED ASSETS						
12.00	Land	26,070,000	0	0	0	12.00
13.00	Land improvements	462,328	0	0	0	13.00
14.00	Accumulated depreciation	-74,198	0	0	0	14.00
15.00	Buildings	69,138,576	0	0	0	15.00
16.00	Accumulated depreciation	-3,285,242	0	0	0	16.00
17.00	Leasehold improvements	2,484,822	0	0	0	17.00
18.00	Accumulated depreciation	-189,320	0	0	0	18.00
19.00	Fixed equipment	5,167,215	0	0	0	19.00
20.00	Accumulated depreciation	-1,188,785	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	13,476,619	0	0	0	23.00
24.00	Accumulated depreciation	-4,263,449	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)	107,798,566	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,434,433	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,434,433	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	140,703,068	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	6,743,507	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	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	5,208,276	0	0	0	43.00
44.00	Other current liabilities	23,932,285	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	35,884,068	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	13,814,824	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	13,814,824	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	49,698,892	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	91,004,176				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	91,004,176	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	140,703,068	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019

Worksheet G-1

Date/Time Prepared:
12/5/2019 9:25 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		92,692,776		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-12,632,729				2.00
3.00	Total (sum of line 1 and line 2)		80,060,047		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00	TRANSFER FROM AFFILIATE	10,944,128		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)		10,944,128		0		10.00
11.00	Subtotal (line 3 plus line 10)		91,004,175		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)		91,004,175		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	TRANSFER FROM AFFILIATE		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: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
12/5/2019 9:25 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	148,072,906		148,072,906	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	1,026,037		1,026,037	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	7,508,060		7,508,060	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)	156,607,003		156,607,003	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	14,193,669		14,193,669	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	14,193,669		14,193,669	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	170,800,672		170,800,672	17.00
18.00	Ancillary services	287,586,253	338,289,556	625,875,809	18.00
19.00	Outpatient services	0	44,361,193	44,361,193	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER MISC REVENUES	354,189	17,327,099	17,681,288	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	458,741,114	399,977,848	858,718,962	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		211,990,708		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	RECONCILING ITEM	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)		211,990,708		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019

Worksheet G-3

Date/Time Prepared:
12/5/2019 9:25 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	858,718,962	1.00
2.00	Less contractual allowances and discounts on patients' accounts	665,316,482	2.00
3.00	Net patient revenues (line 1 minus line 2)	193,402,480	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	211,990,708	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-18,588,228	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	2,421	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	1,013,816	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	REVENUE FROM OTHER SOURCES	4,818,124	24.00
24.01	NET ASSETS RELEASED FROM RESTRICTION	121,138	24.01
25.00	Total other income (sum of lines 6-24)	5,955,499	25.00
26.00	Total (line 5 plus line 25)	-12,632,729	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)	-12,632,729	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0224	Period: From 07/01/2018 To 06/30/2019	Worksheet L Parts I-III Date/Time Prepared: 12/5/2019 9:25 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,657,603	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		97,471	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)		99.91	3.00
4.00	Number of interns & residents (see instructions)		119.26	4.00
5.00	Indirect medical education percentage (see instructions)		40.06	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)		664,036	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30)(see instructions)		6.97	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		23.42	8.00
9.00	Sum of lines 7 and 8		30.39	9.00
10.00	Allowable disproportionate share percentage (see instructions)		6.34	10.00
11.00	Disproportionate share adjustment (see instructions)		105,092	11.00
12.00	Total prospective capital payments (see instructions)		2,524,202	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

ALL INCLUSIVE RATE DATA - METHOD E

Provider CCN: 14-0224

Period:
From 07/01/2018
To 06/30/2019Worksheet AIR
Not a CMS Worksheet
Date/Time Prepared:
12/5/2019 9:25 am

		1.00	
1.00	Total general inpatient routine service cost.	43,048,666	1.00
2.00	Total inpatient days.	38,518	2.00
3.00	Cost per day.	1,117.62	3.00
4.00	Percentage (93% = Short Term; 98% = Long Term).	0	4.00
5.00	Reduced cost per day.	0.00	5.00
6.00	Ancillary percentage.	0	6.00
7.00	Ancillary cost per day.	0.00	7.00
8.00	Inpatient Part B days.	0	8.00
9.00	Total Part B ancillary cost.	0	9.00