

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: 14-0304	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 3/20/2020 1:16 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 3/20/2020	Time: 1:16 pm
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ADVENTIST BOLINGBROOK HOSPITAL (14-0304) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) JARED BROWN

Officer or Administrator of Provider(s)

CFO

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	14,485	-10,948	0	0	1.00
2.00	Subprovider - IPF	0	10,311	2,885		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	24,796	-8,063	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: 14-0304		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 3/20/2020 1:16 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 500 REMINGTON BLVD			PO Box:				1.00	
2.00	City: BOLINGBROOK			State: IL		Zip Code: 60440-		County: WILL	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			ADVENTIST BOLINGBROOK HOSPITAL	140304	16974	1	01/13/2008	N
4.00	Subprovider - IPF			ADVENTIST BOLINGBROOK HOSPITAL PSYCH	14S304	16974	4	01/01/2016	N
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2019	12/31/2019	20.00
21.00	Type of Control (see instructions)						1		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	Y	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					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.			592	1,185	4	13	3,657	0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0304

Period:
From 01/01/2019
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Part I
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	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
					Urban/Rural S	Date of Geogr	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					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	Y
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N		
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1.00	2.00	3.00	
60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)				N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0304

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part I
Date/Time Prepared:
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	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00	2.00	3.00	4.00		
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
	Unweighted FTEs Nonprovider Site		Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
	1.00	2.00	3.00			
64.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		64.00

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

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

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			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
			1.00	2.00	3.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	2,094,309	0	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		HF8013	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0304		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 3/20/2020 1:16 pm					
1.00		2.00		3.00									
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.													
141.00	Name: ADVENTHEALTH		Contractor's Name: FIRST COAST SERVICE OPTIONS		Contractor's Number: 09001		141.00						
142.00	Street: 900 HOPE WAY		PO Box:				142.00						
143.00	City: ALTAMONTE SPRINGS		State: FL		Zip Code: 32714		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		N	161.00		
								1.00					
Multicampus													
165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N		165.00			
				Name		County		State		Zip Code	CBSA	FTE/Campus	
				0		1.00		2.00		3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)											0.00	166.00
								1.00					
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act													
167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y		167.00			
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)										168.00			
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)										168.01			
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								9.99		169.00			
								Beginning		Ending			
								1.00		2.00			
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)										170.00			
								1.00		2.00			
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)								N		0	171.00		

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0304	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 3/20/2020 1:16 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		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	03/09/2020	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		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: 14-0304

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part II
Date/Time Prepared:
3/20/2020 1:16 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		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.	MARY JO		MACKNISKAS	41.00
42.00	Enter the employer/company name of the cost report preparer.	AMITA			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	224-273-0184		MARYJO.MACKNISKAS@AMITAHEALT H.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0304	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 3/20/2020 1:16 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SR DIRECTOR NET REV AND REIMB		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0304

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
3/20/2020 1:16 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	98	35,770	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)		98	35,770	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,380	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		110	40,150	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	24	8,760		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
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)		134			0	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)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0304

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
3/20/2020 1:16 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	5,581	1,235	17,077			1.00
2.00	HMO and other (see instructions)	2,806	3,657				2.00
3.00	HMO IPF Subprovider	1,080	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	5,581	1,235	17,077			7.00
8.00	INTENSIVE CARE UNIT	830	43	2,198			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		498	2,499			13.00
14.00	Total (see instructions)	6,411	1,776	21,774	0.00	771.52	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	4,411	0	6,038	0.00	67.34	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			290			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	838.86	27.00
28.00	Observation Bed Days		99	2,939			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	18	149			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0304

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
3/20/2020 1:16 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,680	212	5,794	1.00
2.00 HMO and other (see instructions)			614	968		2.00
3.00 HMO IPF Subprovider				1		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,680	212	5,794	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	340	0	452	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0304

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part II
Date/Time Prepared:
3/20/2020 1:16 pm

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	37,121,422	-48,255	37,073,167	1,744,833.98	21.25
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		2,663,900	0	2,663,900	156,388.99	17.03
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		532,016	0	532,016	16,155.00	32.93
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		146,236	0	146,236	1,113.00	131.39
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		4,487,368	0	4,487,368	74,076.00	60.58
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		7,667,722	0	7,667,722		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		600,000	0	600,000		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		1,200,000	0	1,200,000		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	0	0	0	0.00	0.00
27.00	Administrative & General	5.00	1,678,304	-313	1,677,991	21,482.81	78.11

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0304

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part II
Date/Time Prepared:
3/20/2020 1:16 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		39,964	0	39,964	228.00	175.28	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,209,372	0	1,209,372	80,244.65	15.07	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,892,502	0	1,892,502	92,587.00	20.44	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		1,578,262	0	1,578,262	65,464.00	24.11	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,278,984	0	1,278,984	33,700.35	37.95	38.00
39.00	Central Services and Supply	14.00	169,409	0	169,409	16,790.50	10.09	39.00
40.00	Pharmacy	15.00	1,571,629	0	1,571,629	50,482.43	31.13	40.00
41.00	Medical Records & Medical Records Library	16.00	13,591	0	13,591	861.86	15.77	41.00
42.00	Social Service	17.00	320,862	0	320,862	9,304.70	34.48	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0304

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part III
Date/Time Prepared:
3/20/2020 1:16 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	40,632,150	-48,255	40,583,895	1,903,112.98	21.33	1.00
2.00	Excluded area salaries (see instructions)	2,663,900	0	2,663,900	156,388.99	17.03	2.00
3.00	Subtotal salaries (line 1 minus line 2)	37,968,250	-48,255	37,919,995	1,746,723.99	21.71	3.00
4.00	Subtotal other wages & related costs (see inst.)	5,165,620	0	5,165,620	91,344.00	56.55	4.00
5.00	Subtotal wage-related costs (see inst.)	8,867,722	0	8,867,722	0.00	23.39	5.00
6.00	Total (sum of lines 3 thru 5)	52,001,592	-48,255	51,953,337	1,838,067.99	28.27	6.00
7.00	Total overhead cost (see instructions)	9,752,879	-313	9,752,566	371,146.30	26.28	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0304	Period: From 01/01/2019 To 12/31/2019	Worksheet S-3 Part IV Date/Time Prepared: 3/20/2020 1:16 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			0 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		1,078,877	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		3,854,440	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		-67,606	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)		0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		395,639	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		2,798,421	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		71,468	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		86,483	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		8,217,722	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0304

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part V
Date/Time Prepared:
3/20/2020 1:16 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	532,016	8,239,291	1.00
2.00	Hospital	532,016	8,239,291	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0304	Period: From 01/01/2019 To 12/31/2019	Worksheet S-10 Date/Time Prepared: 3/20/2020 1:16 pm	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.208043		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		16,068,555		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0		5.00
6.00	Medicaid charges		103,095,018		6.00
7.00	Medicaid cost (line 1 times line 6)		21,448,197		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)		5,379,642		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)		5,379,642		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)	14,412,097	942,916	15,355,013	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,998,336	942,916	3,941,252	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)	2,998,336	942,916	3,941,252	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)		9,548,247		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		413,542		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		636,219		27.01
28.00	Non-Medicare bad debt expense (see instructions)		8,912,028		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		2,076,762		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		6,018,014		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		11,397,656		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0304

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

Worksheet A

Date/Time Prepared:
3/20/2020 1:16 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	6,520,174	6,520,174	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	2,724,117	2,724,117	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,211,174	5,211,174	0	5,211,174	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,678,304	32,349,210	34,027,514	-217,685	33,809,829	5.00
7.00	00700	OPERATION OF PLANT	1,209,372	3,482,073	4,691,445	-14,550	4,676,895	7.00
9.00	00900	HOUSEKEEPING	0	2,643,392	2,643,392	2,816	2,646,208	9.00
10.00	01000	DIETARY	0	2,429,538	2,429,538	-1,876,479	553,059	10.00
11.00	01100	CAFETERIA	0	0	0	1,876,479	1,876,479	11.00
13.00	01300	NURSING ADMINISTRATION	1,278,984	275,851	1,554,835	-6,817	1,548,018	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	169,409	419,995	589,404	-495,417	93,987	14.00
15.00	01500	PHARMACY	1,571,629	6,991,987	8,563,616	-6,754,736	1,808,880	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,591	27,391	40,982	-160	40,822	16.00
17.00	01700	SOCIAL SERVICE	320,862	130,085	450,947	-90	450,857	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,030,853	1,597,496	9,628,349	-1,291,789	8,336,560	30.00
31.00	03100	INTENSIVE CARE UNIT	1,906,540	965,363	2,871,903	-362,331	2,509,572	31.00
40.00	04000	SUBPROVIDER - IPF	2,132,367	346,208	2,478,575	-72,295	2,406,280	40.00
43.00	04300	NURSERY	198	26,549	26,747	1,106,522	1,133,269	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,073,048	10,650,533	14,723,581	-9,232,897	5,490,684	50.00
51.00	05100	RECOVERY ROOM	610,094	79,586	689,680	-27,855	661,825	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,748,374	845,945	2,594,319	-465,007	2,129,312	52.00
53.00	05300	ANESTHESIOLOGY	53,074	280,693	333,767	-251,772	81,995	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,221,502	1,581,550	3,803,052	-669,995	3,133,057	54.00
56.00	05600	RADIOISOTOPE	163,581	27,643	191,224	7,481	198,705	56.00
57.00	05700	CT SCAN	493,244	287,064	780,308	129,985	910,293	57.00
58.00	05800	MRI	241,368	31,530	272,898	59,779	332,677	58.00
59.00	05900	CARDIAC CATHETERIZATION	519,724	733,004	1,252,728	-679,844	572,884	59.00
60.00	06000	LABORATORY	1,516,349	2,192,014	3,708,363	-1,052,024	2,656,339	60.00
65.00	06500	RESPIRATORY THERAPY	847,997	286,293	1,134,290	-127,121	1,007,169	65.00
66.00	06600	PHYSICAL THERAPY	0	5,160,381	5,160,381	-310,383	4,849,998	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	179,826	179,826	0	179,826	67.00
68.00	06800	SPEECH PATHOLOGY	0	7,680	7,680	0	7,680	68.00
69.00	06900	ELECTROCARDIOLOGY	520,938	472,432	993,370	-33,921	959,449	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	47,716	301,940	349,656	-3,207	346,449	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	8,596,074	8,596,074	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,571,313	4,571,313	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,591,059	6,591,059	73.00
74.00	07400	RENAL DIALYSIS	0	411,320	411,320	0	411,320	74.00
76.00	03020	ANCILLARY	0	0	0	0	0	76.00
76.01	03950	WOUND CARE	10,235	18,916	29,151	-4,657	24,494	76.01
76.97	07697	CARDIAC REHABILITATION	138,357	14,961	153,318	-1,381	151,937	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,223,771	441,513	1,665,284	-49,496	1,615,788	90.00
90.01	09001	ACI	10,894	3,598	14,492	0	14,492	90.01
91.00	09100	EMERGENCY	3,837,514	1,845,093	5,682,607	-684,743	4,997,864	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		7,607,251	7,607,251	-7,499,147	108,104	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,589,889	90,357,078	126,946,967	0	126,946,967	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	78,429	24,372	102,801	0	102,801	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,090,468	2,090,468	0	2,090,468	192.00
194.00	07950	FOUNDATION	16,873	10,334	27,207	0	27,207	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	PROF OFFICE BUILDINGS	0	61,082	61,082	0	61,082	194.02
194.03	07953	OP PHARMACY	308,385	1,707,157	2,015,542	0	2,015,542	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	127,846	129,936	257,782	0	257,782	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	37,121,422	94,380,427	131,501,849	0	131,501,849	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0304

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

Worksheet A

Date/Time Prepared:
3/20/2020 1:16 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	134,196	6,654,370	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	465,482	3,189,599	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-863,788	4,347,386	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-6,740,689	27,069,140	5.00
7.00	00700	OPERATION OF PLANT	-34,640	4,642,255	7.00
9.00	00900	HOUSEKEEPING	0	2,646,208	9.00
10.00	01000	DIETARY	-482,187	70,872	10.00
11.00	01100	CAFETERIA	0	1,876,479	11.00
13.00	01300	NURSING ADMINISTRATION	-1,961	1,546,057	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	93,987	14.00
15.00	01500	PHARMACY	0	1,808,880	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	702,078	742,900	16.00
17.00	01700	SOCIAL SERVICE	-26,686	424,171	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-253,953	8,082,607	30.00
31.00	03100	INTENSIVE CARE UNIT	-89,983	2,419,589	31.00
40.00	04000	SUBPROVIDER - IPF	0	2,406,280	40.00
43.00	04300	NURSERY	-3,000	1,130,269	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-552,320	4,938,364	50.00
51.00	05100	RECOVERY ROOM	-55	661,770	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-358,006	1,771,306	52.00
53.00	05300	ANESTHESIOLOGY	-2,000	79,995	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-643,109	2,489,948	54.00
56.00	05600	RADIOISOTOPE	0	198,705	56.00
57.00	05700	CT SCAN	-142	910,151	57.00
58.00	05800	MRI	0	332,677	58.00
59.00	05900	CARDIAC CATHETERIZATION	-4,989	567,895	59.00
60.00	06000	LABORATORY	-703	2,655,636	60.00
65.00	06500	RESPIRATORY THERAPY	-6,318	1,000,851	65.00
66.00	06600	PHYSICAL THERAPY	-288	4,849,710	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	179,826	67.00
68.00	06800	SPEECH PATHOLOGY	-69	7,611	68.00
69.00	06900	ELECTROCARDIOLOGY	-268,376	691,073	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-112,514	233,935	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-2,449	8,593,625	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	299	4,571,612	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-48,135	6,542,924	73.00
74.00	07400	RENAL DIALYSIS	0	411,320	74.00
76.00	03020	ANCILLARY	0	0	76.00
76.01	03950	WOUND CARE	0	24,494	76.01
76.97	07697	CARDIAC REHABILITATION	0	151,937	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-33,885	1,581,903	90.00
90.01	09001	ACI	0	14,492	90.01
91.00	09100	EMERGENCY	-602,149	4,395,715	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-108,104	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-9,938,443	117,008,524	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	102,801	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-2,114,044	-23,576	192.00
194.00	07950	FOUNDATION	0	27,207	194.00
194.01	07951	MARKETING	0	0	194.01
194.02	07952	PROF OFFICE BUILDINGS	0	61,082	194.02
194.03	07953	OP PHARMACY	0	2,015,542	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	257,782	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-12,052,487	119,449,362	200.00

RECLASSIFICATIONS

Provider CCN: 14-0304

Period:
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Date/Time Prepared:
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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	0	1,876,479		1.00
	TOTALS		0	1,876,479		
	B - NURSERY					
1.00	NURSERY	43.00	876,503	253,628		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	27,294		2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	19,646	0		3.00
	TOTALS		896,149	280,922		
	C - PROPERTY					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	62,037		1.00
	TOTALS		0	62,037		
	D - RADIOLOGY ADMIN					
1.00	RADIOISOTOPE	56.00	15,944	4,828		1.00
2.00	CT SCAN	57.00	171,259	51,853		2.00
3.00	MRI	58.00	53,861	16,308		3.00
	TOTALS		241,064	72,989		
	E - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,641,986		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	590,032		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	132		3.00
	TOTALS		0	2,232,150		
	F - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,332,705		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,382,608		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
	TOTALS		0	5,715,313		
	H - BILLABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	8,596,074		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	8,596,074		
	I - DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	6,591,059		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00

RECLASSIFICATIONS

Provider CCN: 14-0304

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

Worksheet A-6

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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
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
TOTALS			0	6,591,059		
J - RENT AND LEASES						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	308,844		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	739,477		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
TOTALS			0	1,048,321		
K - INSURANCE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	174,602		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	12,000		2.00
TOTALS			0	186,602		
L - IMPLANTIBLES						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	4,571,313		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	34,197		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
TOTALS			0	4,605,510		
M - LAUNDRY SERVICES						
1.00	HOUSEKEEPING	9.00	0	6,716		1.00
2.00		0.00	0	0		2.00
TOTALS			0	6,716		
O - PHYS RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	313		1.00
2.00	OPERATING ROOM	50.00	0	10,844		2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1,400		3.00
4.00	ANESTHESIOLOGY	53.00	0	2,000		4.00
5.00	CLINIC	90.00	0	33,698		5.00
TOTALS			0	48,255		
500.00	Grand Total: Increases		1,137,213	31,322,427		500.00

RECLASSIFICATIONS

Provider CCN: 14-0304

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

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Date/Time Prepared:
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		Decreases					3/20/2020 1:16 pm	
		Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
		6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA								
1.00	DIETARY	10.00	0	1,876,479	0		1.00	
		TOTALS	0	1,876,479				
B - NURSERY								
1.00	DELIVERY ROOM & LABOR ROOM	52.00	0	280,922	0		1.00	
2.00	ADULTS & PEDIATRICS	30.00	896,149	0	0		2.00	
3.00		0.00	0	0	0		3.00	
		TOTALS	896,149	280,922				
C - PROPERTY								
1.00	INTEREST EXPENSE	113.00	0	62,037	13		1.00	
		TOTALS	0	62,037				
D - RADIOLOGY ADMIN								
1.00	RADIOLOGY-DIAGNOSTIC	54.00	241,064	72,989	0		1.00	
2.00		0.00	0	0	0		2.00	
3.00		0.00	0	0	0		3.00	
		TOTALS	241,064	72,989				
E - INTEREST RECLASS								
1.00	INTEREST EXPENSE	113.00	0	2,232,150	11		1.00	
2.00		0.00	0	0	11		2.00	
3.00		0.00	0	0	0		3.00	
		TOTALS	0	2,232,150				
F - DEPRECIATION								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	22,748	9		1.00	
2.00	OPERATION OF PLANT	7.00	0	13,950	9		2.00	
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	29,901	0		3.00	
4.00	ADULTS & PEDIATRICS	30.00	0	4,666	0		4.00	
5.00	INTENSIVE CARE UNIT	31.00	0	3,783	0		5.00	
6.00	SUBPROVIDER - IPF	40.00	0	10,279	0		6.00	
7.00	NURSERY	43.00	0	1,051	0		7.00	
8.00	OPERATING ROOM	50.00	0	286,736	0		8.00	
9.00	DELIVERY ROOM & LABOR ROOM	52.00	0	8,569	0		9.00	
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	62,896	0		10.00	
11.00	RADIOISOTOPE	56.00	0	4,928	0		11.00	
12.00	MRI	58.00	0	4,140	0		12.00	
13.00	CARDIAC CATHETERIZATION	59.00	0	16,840	0		13.00	
14.00	LABORATORY	60.00	0	2,923	0		14.00	
15.00	RESPIRATORY THERAPY	65.00	0	12,361	0		15.00	
16.00	ELECTROCARDIOLOGY	69.00	0	22,300	0		16.00	
17.00	EMERGENCY	91.00	0	2,282	0		17.00	
18.00	INTEREST EXPENSE	113.00	0	5,204,960	0		18.00	
		TOTALS	0	5,715,313				
H - BILLABLE SUPPLIES								
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	497,700	0		1.00	
2.00	PHARMACY	15.00	0	79,757	0		2.00	
3.00	MEDICAL RECORDS & LIBRARY	16.00	0	100	0		3.00	
4.00	SOCIAL SERVICE	17.00	0	90	0		4.00	
5.00	ADULTS & PEDIATRICS	30.00	0	403,252	0		5.00	
6.00	INTENSIVE CARE UNIT	31.00	0	354,962	0		6.00	
7.00	SUBPROVIDER - IPF	40.00	0	50,272	0		7.00	
8.00	NURSERY	43.00	0	22,419	0		8.00	
9.00	OPERATING ROOM	50.00	0	4,529,982	0		9.00	
10.00	RECOVERY ROOM	51.00	0	27,648	0		10.00	
11.00	DELIVERY ROOM & LABOR ROOM	52.00	0	178,134	0		11.00	
12.00	ANESTHESIOLOGY	53.00	0	104,222	0		12.00	
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	91,647	0		13.00	
14.00	RADIOISOTOPE	56.00	0	8,363	0		14.00	
15.00	CT SCAN	57.00	0	91,725	0		15.00	
16.00	MRI	58.00	0	6,148	0		16.00	
17.00	CARDIAC CATHETERIZATION	59.00	0	461,477	0		17.00	
18.00	LABORATORY	60.00	0	872,413	0		18.00	
19.00	RESPIRATORY THERAPY	65.00	0	88,625	0		19.00	
20.00	PHYSICAL THERAPY	66.00	0	1,447	0		20.00	
21.00	ELECTROCARDIOLOGY	69.00	0	11,106	0		21.00	
22.00	ELECTROENCEPHALOGRAPHY	70.00	0	3,207	0		22.00	
23.00	WOUND CARE	76.01	0	4,216	0		23.00	
24.00	CARDIAC REHABILITATION	76.97	0	1,381	0		24.00	
25.00	CLINIC	90.00	0	35,006	0		25.00	
26.00	EMERGENCY	91.00	0	670,775	0		26.00	
		TOTALS	0	8,596,074				
I - DRUGS CHARGED TO PATIENTS								
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,013	0		1.00	
2.00	PHARMACY	15.00	0	6,396,692	0		2.00	
3.00	ADULTS & PEDIATRICS	30.00	0	4,321	0		3.00	
4.00	INTENSIVE CARE UNIT	31.00	0	600	0		4.00	

RECLASSIFICATIONS

Provider CCN: 14-0304

Period:
From 01/01/2019
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	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
5.00	SUBPROVIDER - IPF	40.00	0	19	0		5.00
6.00	NURSERY	43.00	0	139	0		6.00
7.00	OPERATING ROOM	50.00	0	30,744	0		7.00
8.00	RECOVERY ROOM	51.00	0	207	0		8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	0	2,372	0		9.00
10.00	ANESTHESIOLOGY	53.00	0	147,550	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,207	0		11.00
12.00	CT SCAN	57.00	0	1,402	0		12.00
13.00	MRI	58.00	0	102	0		13.00
14.00	CARDIAC CATHETERIZATION	59.00	0	36	0		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	195	0		15.00
16.00	WOUND CARE	76.01	0	1	0		16.00
17.00	EMERGENCY	91.00	0	2,459	0		17.00
	TOTALS		0	6,591,059			
J - RENT AND LEASES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	9,667	10		1.00
2.00	OPERATION OF PLANT	7.00	0	600	10		2.00
3.00	HOUSEKEEPING	9.00	0	3,900	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	6,817	0		4.00
5.00	PHARMACY	15.00	0	278,287	0		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	60	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	2,879	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	2,986	0		8.00
9.00	OPERATING ROOM	50.00	0	30,500	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	192,620	0		10.00
11.00	CARDIAC CATHETERIZATION	59.00	0	2,280	0		11.00
12.00	LABORATORY	60.00	0	176,688	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	24,657	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	308,844	0		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	320	0		15.00
16.00	CLINIC	90.00	0	486	0		16.00
17.00	EMERGENCY	91.00	0	6,730	0		17.00
	TOTALS		0	1,048,321			
K - INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	185,402	12		1.00
2.00	EMERGENCY	91.00	0	1,200	12		2.00
	TOTALS		0	186,602			
L - IMPLANTIBLES							
1.00	ADULTS & PEDIATRICS	30.00	0	7,816	0		1.00
2.00	SUBPROVIDER - IPF	40.00	0	11,725	0		2.00
3.00	OPERATING ROOM	50.00	0	4,354,935	0		3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	0	14,656	0		4.00
5.00	CARDIAC CATHETERIZATION	59.00	0	199,211	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	1,478	0		6.00
7.00	PHYSICAL THERAPY	66.00	0	92	0		7.00
8.00	WOUND CARE	76.01	0	440	0		8.00
9.00	CLINIC	90.00	0	13,860	0		9.00
10.00	EMERGENCY	91.00	0	1,297	0		10.00
	TOTALS		0	4,605,510			
M - LAUNDRY SERVICES							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6,572	0		1.00
2.00	CLINIC	90.00	0	144	0		2.00
	TOTALS		0	6,716			
O - PHYS RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	313	0	0		1.00
2.00	OPERATING ROOM	50.00	10,844	0	0		2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	1,400	0	0		3.00
4.00	ANESTHESIOLOGY	53.00	2,000	0	0		4.00
5.00	CLINIC	90.00	33,698	0	0		5.00
	TOTALS		48,255	0			
500.00	Grand Total: Decreases		1,185,468	31,274,172			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0304

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part I
Date/Time Prepared:
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		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	3,750,000	0	0	0	0	1.00	
2.00	Land Improvements	312,035	0	0	0	0	2.00	
3.00	Buildings and Fixtures	112,022,821	0	0	0	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	23,136,181	0	0	0	0	5.00	
6.00	Movable Equipment	39,516,196	1,663,278	0	1,663,278	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	178,737,233	1,663,278	0	1,663,278	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	178,737,233	1,663,278	0	1,663,278	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,750,000	0				1.00	
2.00	Land Improvements	312,035	0				2.00	
3.00	Buildings and Fixtures	112,022,821	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	23,136,181	0				5.00	
6.00	Movable Equipment	41,179,474	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	180,400,511	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	180,400,511	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0304

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part II
Date/Time Prepared:
3/20/2020 1:16 pm

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0304

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part III
Date/Time Prepared:
3/20/2020 1:16 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	139,221,037	0	139,221,037	0.778915	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	39,516,196	0	39,516,196	0.221085	0	2.00
3.00	Total (sum of lines 1-2)	178,737,233	0	178,737,233	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	4,332,705	308,844	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,382,608	739,477	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,715,313	1,048,321	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,838,219	174,602	0	0	6,654,370	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,055,514	12,000	0	0	3,189,599	2.00
3.00	Total (sum of lines 1-2)	2,893,733	186,602	0	0	9,843,969	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0304

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

Worksheet A-8

Date/Time Prepared:
3/20/2020 1:16 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-49,224	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-25,113	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,624,625			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	2,475,232			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	0	0DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	0	0MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
19.02	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.02
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	0PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	0*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	0*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0	0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	0OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	0ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0304

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

Worksheet A-8

Date/Time Prepared:
3/20/2020 1:16 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #	Wkst. A-7 Ref.
				Cost Center			
		1.00	2.00	3.00		4.00	5.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY		68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0			0.00	0 32.00
33.00	OTHER REVENUE	B	-236,086	ADMINISTRATIVE & GENERAL		5.00	0 33.00
33.01	OTHER REVENUE	B	-9,256	OPERATION OF PLANT		7.00	0 33.01
33.02	OTHER REVENUE	B	-482,187	DIETARY		10.00	9 33.02
33.03	OTHER REVENUE	B	-1,605	NURSING ADMINISTRATION		13.00	0 33.03
33.04	OTHER REVENUE	B	-1,751	MEDICAL RECORDS & LIBRARY		16.00	0 33.04
33.05	OTHER REVENUE	B	-75	OPERATING ROOM		50.00	0 33.05
33.06	OTHER REVENUE	B	-9,271	DELIVERY ROOM & LABOR ROOM		52.00	0 33.06
33.07	OTHER REVENUE	B	-4,513	RADIOLOGY-DIAGNOSTIC		54.00	0 33.07
33.08	OTHER REVENUE	B	-4,989	CARDIAC CATHETERIZATION		59.00	0 33.08
33.09	OTHER REVENUE	B	-187	CLINIC		90.00	0 33.09
33.10	OTHER REVENUE	B	-22,379	EMERGENCY		91.00	0 33.10
33.11	STATE ASSESSMENT	A	-6,675,910	ADMINISTRATIVE & GENERAL		5.00	0 33.11
33.12	CHARITY & COMMUNITY SERVICES	A	-2,500	ADMINISTRATIVE & GENERAL		5.00	0 33.12
33.13	CHARITY & COMMUNITY SERVICES	A	-26,686	SOCIAL SERVICE		17.00	0 33.13
33.14	ENTERTAINMENT	A	-133	ADMINISTRATIVE & GENERAL		5.00	0 33.14
33.15	ENTERTAINMENT	A	-284	NURSING ADMINISTRATION		13.00	0 33.15
33.16	ENTERTAINMENT	A	-26	ADULTS & PEDIATRICS		30.00	0 33.16
33.17	INCOME TAXES	A	-12,000	INTEREST EXPENSE		113.00	0 33.17
33.18	DUES & LOBBYING	A	-33,478	ADMINISTRATIVE & GENERAL		5.00	0 33.18
33.19	DUES & LOBBYING	A	-55	RECOVERY ROOM		51.00	0 33.19
33.20	DUES & LOBBYING	A	-63	EMERGENCY		91.00	0 33.20
33.21	ADVERTISING & MARKETING	A	-3,000	NURSERY		43.00	0 33.21
33.22	PROPERTY TAXES	A	-62,037	CAP REL COSTS-BLDG & FIXT		1.00	13 33.22
33.23	NON ALLOW PHYSICIAN FEES	A	-313	ADMINISTRATIVE & GENERAL		5.00	0 33.23
33.24	NON ALLOW PHYSICIAN FEES	A	-69,138	INTENSIVE CARE UNIT		31.00	0 33.24
33.25	NON ALLOW PHYSICIAN FEES	A	-552,245	OPERATING ROOM		50.00	0 33.25
33.26	NON ALLOW PHYSICIAN FEES	A	-348,735	DELIVERY ROOM & LABOR ROOM		52.00	0 33.26
33.27	NON ALLOW PHYSICIAN FEES	A	-2,000	ANESTHESIOLOGY		53.00	0 33.27
33.28	NON ALLOW PHYSICIAN FEES	A	-184,089	RADIOLOGY-DIAGNOSTIC		54.00	0 33.28
33.29	NON ALLOW PHYSICIAN FEES	A	-37,500	ELECTROCARDIOLOGY		69.00	0 33.29
33.30	NON ALLOW PHYSICIAN FEES	A	-112,514	ELECTROENCEPHALOGRAPHY		70.00	0 33.30
33.31	NON ALLOW PHYSICIAN FEES	A	-33,698	CLINIC		90.00	0 33.31
33.32	NON ALLOW PHYSICIAN FEES	A	-520,355	EMERGENCY		91.00	0 33.32
33.33	HOSPICE	A	-355	RADIOLOGY-DIAGNOSTIC		54.00	0 33.33
33.34	HOSPICE	A	-142	CT SCAN		57.00	0 33.34
33.35	HOSPICE	A	-703	LABORATORY		60.00	0 33.35
33.36	HOSPICE	A	-6,318	RESPIRATORY THERAPY		65.00	0 33.36
33.37	HOSPICE	A	-288	PHYSICAL THERAPY		66.00	0 33.37
33.38	HOSPICE	A	-69	SPEECH PATHOLOGY		68.00	0 33.38
33.39	HOSPICE	A	-50	ELECTROCARDIOLOGY		69.00	0 33.39
33.40	HOSPICE	A	-2,449	MEDICAL SUPPLIES CHARGED TO PATIENT		71.00	0 33.40
33.41	HOSPICE	A	299	IMPL. DEV. CHARGED TO PATIENTS		72.00	0 33.41
33.42	HOSPICE	A	-48,135	DRUGS CHARGED TO PATIENTS		73.00	0 33.42
33.43	HOSPICE	A	-1,425	EMERGENCY		91.00	0 33.43
33.44	HOSPICE	A	-253,927	ADULTS & PEDIATRICS		30.00	0 33.44
33.45	HOSPICE	A	-20,845	INTENSIVE CARE UNIT		31.00	0 33.45
33.46	FEDERAL & STATE INCOME TAX	A	-30,006	ADMINISTRATIVE & GENERAL		5.00	0 33.46
33.47	FEDERAL & STATE INCOME TAX	A	-17	OPERATION OF PLANT		7.00	0 33.47
33.48	FEDERAL & STATE INCOME TAX	A	-72	NURSING ADMINISTRATION		13.00	0 33.48
33.49	FEDERAL & STATE INCOME TAX	A	-6,545	RADIOLOGY-DIAGNOSTIC		54.00	0 33.49
33.50	AMBULANCE	A	-254	OPERATION OF PLANT		7.00	0 33.50
33.51	AMBULANCE	A	-7,772	EMERGENCY		91.00	0 33.51
33.52	CORPORATE SPONSORSHIP	A	-26,000	ADMINISTRATIVE & GENERAL		5.00	0 33.52
33.53	SELF INSURANCE	A	-854,350	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.53
33.54	NON ALLOWABLE BORROWING	A	-6,232	INTEREST EXPENSE		113.00	0 33.54
33.55	INTERCO PHYSICIAN	A	-2,113,594	PHYSICIANS' PRIVATE OFFICES		192.00	0 33.55
33.56	INTERCO PHYSICIAN	A	-450	PHYSICIANS' PRIVATE OFFICES		192.00	0 33.56
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-12,052,487				50.00

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

(2) Basis for adjustment (see instructions).

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0304

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

Worksheet A-8

Date/Time Prepared:
3/20/2020 1:16 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
	1.00	2.00	3.00	4.00	5.00	

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: 14-0304

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

Worksheet A-8-1

Date/Time Prepared:
3/20/2020 1:16 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	1.00	CAP REL COSTS-BLDG & FIXT	AHS HOME OFFICE	139,965	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	AHS HOME OFFICE	465,482	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	AHS HOME OFFICE	17,506	26,944	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	AHS HOME OFFICE	7,603,110	6,451,046	3.01
3.02	16.00	MEDICAL RECORDS & LIBRARY	AHS HOME OFFICE	703,829	0	3.02
3.03	113.00	INTEREST EXPENSE	AHS HOME OFFICE	2,238,382	2,328,254	3.03
3.04	5.00	ADMINISTRATIVE & GENERAL	AHS HOME OFFICE	4,998,165	3,970,015	3.04
3.05	5.00	ADMINISTRATIVE & GENERAL	AHS HOME OFFICE	32,445	0	3.05
3.06	1.00	CAP REL COSTS-BLDG & FIXT	AMITA HOME OFFICE	56,268	0	3.06
4.00	5.00	ADMINISTRATIVE & GENERAL	AMITA HOME OFFICE	910,977	1,445,422	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	MIDWEST REGIONAL SHARED SERV	14,448,700	14,917,916	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	HINSDALE SHARED SERVICES	2,171,170	2,171,170	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			33,785,999	31,310,767	5.00

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

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

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

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

6.00	B		0.00	ADVENTHEALTH	0.00	6.00
7.00	B		0.00	AMITA HEALTH	0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS		Provider CCN: 14-0304	Period: From 01/01/2019 To 12/31/2019	Worksheet A-8-1 Date/Time Prepared: 3/20/2020 1:16 pm
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	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	139,965	11		1.00
2.00	465,482	11		2.00
3.00	-9,438	0		3.00
3.01	1,152,064	0		3.01
3.02	703,829	0		3.02
3.03	-89,872	0		3.03
3.04	1,028,150	0		3.04
3.05	32,445	0		3.05
3.06	56,268	11		3.06
4.00	-534,445	0		4.00
4.01	-469,216	0		4.01
4.02	0	0		4.02
5.00	2,475,232			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	HOME OFFICE		6.00
7.00	HOME OFFICE		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: 14-0304

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

Worksheet A-8-2

Date/Time Prepared:
3/20/2020 1:16 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	896,037	896,037	0	0	0	1.00
2.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	447,607	447,607	0	0	0	2.00
3.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	230,826	230,826	0	0	0	3.00
4.00	91.00	AGGREGATE-EMERGENCY	50,155	12,625	0	0	0	4.00
5.00	0.00	AGGREGATE-	0	0	0	0	0	5.00
6.00	0.00	AGGREGATE-	0	0	0	0	0	6.00
7.00	0.00	AGGREGATE-	0	0	0	0	0	7.00
8.00	0.00	AGGREGATE-	0	0	0	0	0	8.00
9.00	0.00	AGGREGATE-	0	0	0	0	0	9.00
10.00	0.00	AGGREGATE-	0	0	0	0	0	10.00
11.00	0.00	AGGREGATE-	0	0	0	0	0	11.00
12.00	0.00	AGGREGATE-	0	0	0	0	0	12.00
13.00	0.00	AGGREGATE-	0	0	0	0	0	13.00
200.00			1,624,625	1,587,095	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	4.00
5.00	0.00	AGGREGATE-	0	0	0	0	0	5.00
6.00	0.00	AGGREGATE-	0	0	0	0	0	6.00
7.00	0.00	AGGREGATE-	0	0	0	0	0	7.00
8.00	0.00	AGGREGATE-	0	0	0	0	0	8.00
9.00	0.00	AGGREGATE-	0	0	0	0	0	9.00
10.00	0.00	AGGREGATE-	0	0	0	0	0	10.00
11.00	0.00	AGGREGATE-	0	0	0	0	0	11.00
12.00	0.00	AGGREGATE-	0	0	0	0	0	12.00
13.00	0.00	AGGREGATE-	0	0	0	0	0	13.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	896,037		1.00
2.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	447,607		2.00
3.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	230,826		3.00
4.00	91.00	AGGREGATE-EMERGENCY	0	0	0	50,155		4.00
5.00	0.00	AGGREGATE-	0	0	0	0		5.00
6.00	0.00	AGGREGATE-	0	0	0	0		6.00
7.00	0.00	AGGREGATE-	0	0	0	0		7.00
8.00	0.00	AGGREGATE-	0	0	0	0		8.00
9.00	0.00	AGGREGATE-	0	0	0	0		9.00
10.00	0.00	AGGREGATE-	0	0	0	0		10.00
11.00	0.00	AGGREGATE-	0	0	0	0		11.00
12.00	0.00	AGGREGATE-	0	0	0	0		12.00
13.00	0.00	AGGREGATE-	0	0	0	0		13.00
200.00			0	0	0	1,624,625		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0304

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
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Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	6,654,370	6,654,370				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,189,599		3,189,599			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,347,386	0	0	4,347,386		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	27,069,140	277,474	133,000	196,770	27,676,384	5.00
7.00	00700	OPERATION OF PLANT	4,642,255	348,595	167,090	141,817	5,299,757	7.00
9.00	00900	HOUSEKEEPING	2,646,208	31,930	15,305	0	2,693,443	9.00
10.00	01000	DIETARY	70,872	168,006	80,529	0	319,407	10.00
11.00	01100	CAFETERIA	1,876,479	62,649	30,029	0	1,969,157	11.00
13.00	01300	NURSING ADMINISTRATION	1,546,057	104,627	50,150	149,980	1,850,814	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	93,987	110,909	53,161	19,866	277,923	14.00
15.00	01500	PHARMACY	1,808,880	43,937	21,060	184,297	2,058,174	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	742,900	65,339	31,318	1,594	841,151	16.00
17.00	01700	SOCIAL SERVICE	424,171	13,852	6,639	37,626	482,288	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,082,607	1,192,635	571,660	836,653	10,683,555	30.00
31.00	03100	INTENSIVE CARE UNIT	2,419,589	227,139	108,873	223,570	2,979,171	31.00
40.00	04000	SUBPROVIDER - IPF	2,406,280	282,930	135,615	250,052	3,074,877	40.00
43.00	04300	NURSERY	1,130,269	69,162	33,151	102,806	1,335,388	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,938,364	699,937	335,497	476,354	6,450,152	50.00
51.00	05100	RECOVERY ROOM	661,770	68,317	32,746	71,543	834,376	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,771,306	243,546	116,737	207,163	2,338,752	52.00
53.00	05300	ANESTHESIOLOGY	79,995	11,969	5,737	5,989	103,690	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,489,948	443,289	212,479	232,236	3,377,952	54.00
56.00	05600	RADIOISOTOPE	198,705	140,322	67,260	21,052	427,339	56.00
57.00	05700	CT SCAN	910,151	25,129	12,045	77,923	1,025,248	57.00
58.00	05800	MRI	332,677	17,675	8,472	34,620	393,444	58.00
59.00	05900	CARDIAC CATHETERIZATION	567,895	21,613	10,360	60,945	660,813	59.00
60.00	06000	LABORATORY	2,655,636	76,213	36,530	177,815	2,946,194	60.00
65.00	06500	RESPIRATORY THERAPY	1,000,851	10,374	4,973	99,440	1,115,638	65.00
66.00	06600	PHYSICAL THERAPY	4,849,710	264,467	126,766	0	5,240,943	66.00
67.00	06700	OCCUPATIONAL THERAPY	179,826	18,328	8,785	0	206,939	67.00
68.00	06800	SPEECH PATHOLOGY	7,611	1,614	774	0	9,999	68.00
69.00	06900	ELECTROCARDIOLOGY	691,073	11,277	5,405	61,088	768,843	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	233,935	26,512	12,708	5,595	278,750	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,593,625	0	0	0	8,593,625	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,571,612	0	0	0	4,571,612	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,542,924	0	0	0	6,542,924	73.00
74.00	07400	RENAL DIALYSIS	411,320	0	0	0	411,320	74.00
76.00	03020	ANCILLARY	0	0	0	0	0	76.00
76.01	03950	WOUND CARE	24,494	49,950	23,942	1,200	99,586	76.01
76.97	07697	CARDIAC REHABILITATION	151,937	31,142	14,927	16,224	214,230	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,581,903	146,738	70,335	139,554	1,938,530	90.00
90.01	09001	ACI	14,492	1,035,910	496,537	1,277	1,548,216	90.01
91.00	09100	EMERGENCY	4,395,715	281,489	134,924	450,006	5,262,134	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	117,008,524	6,624,995	3,175,519	4,285,055	116,902,738	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	102,801	15,792	7,569	9,197	135,359	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-23,576	0	0	0	-23,576	192.00
194.00	07950	FOUNDATION	27,207	9,087	4,356	1,979	42,629	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	PROF OFFICE BUILDINGS	61,082	0	0	0	61,082	194.02
194.03	07953	OP PHARMACY	2,015,542	4,496	2,155	36,163	2,058,356	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	257,782	0	0	14,992	272,774	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	119,449,362	6,654,370	3,189,599	4,347,386	119,449,362	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0304

Period:
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To 12/31/2019Worksheet B
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	
		5.00	7.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	27,676,384				5.00
7.00	00700	OPERATION OF PLANT	1,597,861	6,897,618			7.00
9.00	00900	HOUSEKEEPING	812,065	36,534	3,542,042		9.00
10.00	01000	DIETARY	96,300	192,233	99,241	707,181	10.00
11.00	01100	CAFETERIA	593,695	71,683	37,007	546,391	3,217,933
13.00	01300	NURSING ADMINISTRATION	558,015	119,714	61,803	0	66,251
14.00	01400	CENTRAL SERVICES & SUPPLY	83,793	126,902	65,514	0	33,010
15.00	01500	PHARMACY	620,533	50,273	25,953	0	99,243
16.00	01600	MEDICAL RECORDS & LIBRARY	253,605	74,761	38,595	0	1,695
17.00	01700	SOCIAL SERVICE	145,408	15,849	8,182	0	18,293
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,221,059	1,364,626	704,488	108,475	855,804
31.00	03100	INTENSIVE CARE UNIT	898,211	259,894	134,170	13,961	169,512
40.00	04000	SUBPROVIDER - IPF	927,066	323,730	167,126	38,354	275,359
43.00	04300	NURSERY	402,615	79,135	40,854	0	87,149
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,944,701	800,872	413,451	0	287,611
51.00	05100	RECOVERY ROOM	251,562	78,168	40,354	0	45,009
52.00	05200	DELIVERY ROOM & LABOR ROOM	705,127	278,667	143,862	0	175,605
53.00	05300	ANESTHESIOLOGY	31,262	13,695	7,070	0	4,443
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,018,442	507,214	261,850	0	162,612
56.00	05600	RADIOISOTOPE	128,841	160,557	82,888	0	19,211
57.00	05700	CT SCAN	309,109	28,753	14,844	0	53,569
58.00	05800	MRI	118,622	20,223	10,440	0	27,536
59.00	05900	CARDIAC CATHETERIZATION	199,233	24,730	12,767	0	65,026
60.00	06000	LABORATORY	888,269	87,203	45,019	0	151,542
65.00	06500	RESPIRATORY THERAPY	336,362	11,870	6,128	0	91,116
66.00	06600	PHYSICAL THERAPY	1,580,129	302,605	156,220	0	0
67.00	06700	OCCUPATIONAL THERAPY	62,391	20,971	10,826	0	0
68.00	06800	SPEECH PATHOLOGY	3,015	1,846	953	0	0
69.00	06900	ELECTROCARDIOLOGY	231,804	12,903	6,661	0	43,940
70.00	07000	ELECTROENCEPHALOGRAPHY	84,042	30,335	15,661	0	2,389
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,590,952	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,378,327	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,972,672	0	0	0	0
74.00	07400	RENAL DIALYSIS	124,012	0	0	0	0
76.00	03020	ANCILLARY	0	0	0	0	0
76.01	03950	WOUND CARE	30,025	57,153	29,505	0	464
76.97	07697	CARDIAC REHABILITATION	64,590	35,633	18,396	0	8,825
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	584,461	167,899	86,678	0	71,767
90.01	09001	ACI	466,782	1,185,295	611,910	0	0
91.00	09100	EMERGENCY	1,586,518	322,081	166,275	0	380,458
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,901,476	6,864,007	3,524,691	707,181	3,197,439
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	40,810	18,069	9,328	0	6,680
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	FOUNDATION	12,853	10,398	5,368	0	2,359
194.01	07951	MARKETING	0	0	0	0	0
194.02	07952	PROF OFFICE BUILDINGS	18,416	0	0	0	0
194.03	07953	OP PHARMACY	620,588	5,144	2,655	0	11,455
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	82,241	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	27,676,384	6,897,618	3,542,042	707,181	3,217,933

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0304

Period:
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Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	2,656,597				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	587,142			14.00
15.00	01500	PHARMACY	0	5,448	2,859,624		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7	0	1,209,814	16.00
17.00	01700	SOCIAL SERVICE	0	6	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	966,339	27,543	1,495	61,532	30.00
31.00	03100	INTENSIVE CARE UNIT	191,407	24,245	208	11,419	31.00
40.00	04000	SUBPROVIDER - IPF	310,925	3,434	7	21,182	40.00
43.00	04300	NURSERY	98,405	1,531	48	6,446	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	324,759	309,402	10,639	130,247	50.00
51.00	05100	RECOVERY ROOM	50,823	1,888	72	12,925	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	198,286	12,167	821	18,097	52.00
53.00	05300	ANESTHESIOLOGY	5,017	7,119	51,057	36,040	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,260	764	93,153	54.00
56.00	05600	RADIOISOTOPE	0	571	0	12,288	56.00
57.00	05700	CT SCAN	0	6,265	485	131,940	57.00
58.00	05800	MRI	0	420	35	30,038	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	31,520	12	12,048	59.00
60.00	06000	LABORATORY	0	59,588	0	123,953	60.00
65.00	06500	RESPIRATORY THERAPY	0	6,053	0	24,416	65.00
66.00	06600	PHYSICAL THERAPY	0	99	0	36,723	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,305	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	777	68.00
69.00	06900	ELECTROCARDIOLOGY	0	759	67	38,854	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	219	0	5,770	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	33,994	0	25,786	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	52,733	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,213,482	122,174	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,876	74.00
76.00	03020	ANCILLARY	0	0	0	0	76.00
76.01	03950	WOUND CARE	0	288	0	16	76.01
76.97	07697	CARDIAC REHABILITATION	0	94	0	1,485	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	81,037	2,391	0	15,447	90.00
90.01	09001	ACI	0	0	0	244	90.01
91.00	09100	EMERGENCY	429,599	45,815	851	177,900	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				64,037	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,656,597	587,126	2,280,043	1,209,814	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	FOUNDATION	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	194.01
194.02	07952	PROF OFFICE BUILDINGS	0	13	0	0	194.02
194.03	07953	OP PHARMACY	0	0	579,581	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,656,597	587,142	2,859,624	1,209,814	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0304

Period:
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,367,002	0	18,367,002	30.00
31.00	03100	INTENSIVE CARE UNIT	4,730,090	0	4,730,090	31.00
40.00	04000	SUBPROVIDER - IPF	5,273,621	0	5,273,621	40.00
43.00	04300	NURSERY	2,106,021	0	2,106,021	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,671,834	0	10,671,834	50.00
51.00	05100	RECOVERY ROOM	1,315,177	0	1,315,177	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,871,384	0	3,871,384	52.00
53.00	05300	ANESTHESIOLOGY	259,393	0	259,393	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,428,247	0	5,428,247	54.00
56.00	05600	RADIOISOTOPE	831,695	0	831,695	56.00
57.00	05700	CT SCAN	1,570,213	0	1,570,213	57.00
58.00	05800	MRI	600,758	0	600,758	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,006,149	0	1,006,149	59.00
60.00	06000	LABORATORY	4,301,768	0	4,301,768	60.00
65.00	06500	RESPIRATORY THERAPY	1,591,583	0	1,591,583	65.00
66.00	06600	PHYSICAL THERAPY	7,316,719	0	7,316,719	66.00
67.00	06700	OCCUPATIONAL THERAPY	304,432	0	304,432	67.00
68.00	06800	SPEECH PATHOLOGY	16,590	0	16,590	68.00
69.00	06900	ELECTROCARDIOLOGY	1,103,831	0	1,103,831	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	417,166	0	417,166	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,244,357	0	11,244,357	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,002,672	0	6,002,672	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,851,252	0	10,851,252	73.00
74.00	07400	RENAL DIALYSIS	538,208	0	538,208	74.00
76.00	03020	ANCILLARY	0	0	0	76.00
76.01	03950	WOUND CARE	217,037	0	217,037	76.01
76.97	07697	CARDIAC REHABILITATION	343,253	0	343,253	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,948,210	0	2,948,210	90.00
90.01	09001	ACI	3,812,447	0	3,812,447	90.01
91.00	09100	EMERGENCY	8,435,668	0	8,435,668	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	115,476,777	0	115,476,777	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	210,249	0	210,249	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-23,576	0	-23,576	192.00
194.00	07950	FOUNDATION	73,607	0	73,607	194.00
194.01	07951	MARKETING	0	0	0	194.01
194.02	07952	PROF OFFICE BUILDINGS	79,511	0	79,511	194.02
194.03	07953	OP PHARMACY	3,277,779	0	3,277,779	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	355,015	0	355,015	194.04
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	119,449,362	0	119,449,362	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0304

Period:
From 01/01/2019
To 12/31/2019Worksheet B
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	277,474	133,000	410,474	5.00
7.00	00700	OPERATION OF PLANT	0	348,595	167,090	515,685	7.00
9.00	00900	HOUSEKEEPING	0	31,930	15,305	47,235	9.00
10.00	01000	DIETARY	0	168,006	80,529	248,535	10.00
11.00	01100	CAFETERIA	0	62,649	30,029	92,678	11.00
13.00	01300	NURSING ADMINISTRATION	0	104,627	50,150	154,777	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	110,909	53,161	164,070	14.00
15.00	01500	PHARMACY	0	43,937	21,060	64,997	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	65,339	31,318	96,657	16.00
17.00	01700	SOCIAL SERVICE	0	13,852	6,639	20,491	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	1,192,635	571,660	1,764,295	30.00
31.00	03100	INTENSIVE CARE UNIT	0	227,139	108,873	336,012	31.00
40.00	04000	SUBPROVIDER - IPF	0	282,930	135,615	418,545	40.00
43.00	04300	NURSERY	0	69,162	33,151	102,313	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	699,937	335,497	1,035,434	50.00
51.00	05100	RECOVERY ROOM	0	68,317	32,746	101,063	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	243,546	116,737	360,283	52.00
53.00	05300	ANESTHESIOLOGY	0	11,969	5,737	17,706	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	443,289	212,479	655,768	54.00
56.00	05600	RADIOISOTOPE	0	140,322	67,260	207,582	56.00
57.00	05700	CT SCAN	0	25,129	12,045	37,174	57.00
58.00	05800	MRI	0	17,675	8,472	26,147	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	21,613	10,360	31,973	59.00
60.00	06000	LABORATORY	0	76,213	36,530	112,743	60.00
65.00	06500	RESPIRATORY THERAPY	0	10,374	4,973	15,347	65.00
66.00	06600	PHYSICAL THERAPY	0	264,467	126,766	391,233	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	18,328	8,785	27,113	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,614	774	2,388	68.00
69.00	06900	ELECTROCARDIOLOGY	0	11,277	5,405	16,682	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	26,512	12,708	39,220	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	03020	ANCILLARY	0	0	0	0	76.00
76.01	03950	WOUND CARE	0	49,950	23,942	73,892	76.01
76.97	07697	CARDIAC REHABILITATION	0	31,142	14,927	46,069	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	146,738	70,335	217,073	90.00
90.01	09001	ACI	0	1,035,910	496,537	1,532,447	90.01
91.00	09100	EMERGENCY	0	281,489	134,924	416,413	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	6,624,995	3,175,519	9,800,514	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,792	7,569	23,361	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	FOUNDATION	0	9,087	4,356	13,443	194.00
194.01	07951	MARKETING	0	0	0	0	194.01
194.02	07952	PROF OFFICE BUILDINGS	0	0	0	0	194.02
194.03	07953	OP PHARMACY	0	4,496	2,155	6,651	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	6,654,370	3,189,599	9,843,969	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0304

Period:
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	
			5.00	7.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	410,474					5.00
7.00	00700	OPERATION OF PLANT	23,701	539,386				7.00
9.00	00900	HOUSEKEEPING	12,045	2,857	62,137			9.00
10.00	01000	DIETARY	1,428	15,032	1,741	266,736		10.00
11.00	01100	CAFETERIA	8,806	5,606	649	206,089	313,828	11.00
13.00	01300	NURSING ADMINISTRATION	8,277	9,362	1,084	0	6,461	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,243	9,924	1,149	0	3,219	14.00
15.00	01500	PHARMACY	9,204	3,931	455	0	9,679	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,762	5,846	677	0	165	16.00
17.00	01700	SOCIAL SERVICE	2,157	1,239	144	0	1,784	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	47,738	106,716	12,354	40,915	83,463	30.00
31.00	03100	INTENSIVE CARE UNIT	13,323	20,323	2,354	5,266	16,532	31.00
40.00	04000	SUBPROVIDER - IPF	13,751	25,315	2,932	14,466	26,854	40.00
43.00	04300	NURSERY	5,972	6,188	717	0	8,499	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	28,845	62,627	7,253	0	28,049	50.00
51.00	05100	RECOVERY ROOM	3,731	6,113	708	0	4,390	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,459	21,791	2,524	0	17,126	52.00
53.00	05300	ANESTHESIOLOGY	464	1,071	124	0	433	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,106	39,664	4,594	0	15,859	54.00
56.00	05600	RADIOISOTOPE	1,911	12,555	1,454	0	1,874	56.00
57.00	05700	CT SCAN	4,585	2,248	260	0	5,224	57.00
58.00	05800	MRI	1,759	1,581	183	0	2,685	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,955	1,934	224	0	6,342	59.00
60.00	06000	LABORATORY	13,175	6,819	790	0	14,779	60.00
65.00	06500	RESPIRATORY THERAPY	4,989	928	108	0	8,886	65.00
66.00	06600	PHYSICAL THERAPY	23,437	23,663	2,741	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	925	1,640	190	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	45	144	17	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,438	1,009	117	0	4,285	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,247	2,372	275	0	233	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	38,431	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,444	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,260	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,839	0	0	0	0	74.00
76.00	03020	ANCILLARY	0	0	0	0	0	76.00
76.01	03950	WOUND CARE	445	4,469	518	0	45	76.01
76.97	07697	CARDIAC REHABILITATION	958	2,786	323	0	861	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	8,669	13,130	1,521	0	6,999	90.00
90.01	09001	ACI	6,924	92,689	10,735	0	0	90.01
91.00	09100	EMERGENCY	23,532	25,186	2,917	0	37,104	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	398,980	536,758	61,832	266,736	311,830	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	605	1,413	164	0	651	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FOUNDATION	191	813	94	0	230	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	PROF OFFICE BUILDINGS	273	0	0	0	0	194.02
194.03	07953	OP PHARMACY	9,205	402	47	0	1,117	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	1,220	0	0	0	0	194.04
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)	410,474	539,386	62,137	266,736	313,828	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0304

Period:
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Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	179,961					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	179,605				14.00
15.00	01500	PHARMACY	0	1,666	89,932			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2	0	107,109		16.00
17.00	01700	SOCIAL SERVICE	0	2	0	0	25,817	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	65,460	8,425	47	5,448	14,338	30.00
31.00	03100	INTENSIVE CARE UNIT	12,966	7,416	7	1,011	1,845	31.00
40.00	04000	SUBPROVIDER - IPF	21,062	1,050	0	1,875	5,069	40.00
43.00	04300	NURSERY	6,666	468	2	571	2,098	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	22,000	94,648	335	11,531	0	50.00
51.00	05100	RECOVERY ROOM	3,443	578	2	1,144	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,432	3,722	26	1,602	0	52.00
53.00	05300	ANESTHESIOLOGY	340	2,178	1,606	3,191	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,915	24	8,247	0	54.00
56.00	05600	RADIOISOTOPE	0	175	0	1,088	0	56.00
57.00	05700	CT SCAN	0	1,916	15	11,681	0	57.00
58.00	05800	MRI	0	128	1	2,659	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	9,642	0	1,067	0	59.00
60.00	06000	LABORATORY	0	18,227	0	10,974	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,852	0	2,162	0	65.00
66.00	06600	PHYSICAL THERAPY	0	30	0	3,251	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	293	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	69	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	232	2	3,440	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	67	0	511	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	10,398	0	2,283	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,669	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	69,612	10,816	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	255	0	74.00
76.00	03020	ANCILLARY	0	0	0	0	0	76.00
76.01	03950	WOUND CARE	0	88	0	1	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	29	0	132	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	5,490	731	0	1,368	0	90.00
90.01	09001	ACI	0	0	0	22	0	90.01
91.00	09100	EMERGENCY	29,102	14,015	27	15,748	2,467	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	179,961	179,600	71,706	107,109	25,817	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	PROF OFFICE BUILDINGS	0	4	0	0	0	194.02
194.03	07953	OP PHARMACY	0	0	18,226	0	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
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)	179,961	179,605	89,932	107,109	25,817	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0304

Period:
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,149,199	0	2,149,199	30.00
31.00	03100	INTENSIVE CARE UNIT	417,055	0	417,055	31.00
40.00	04000	SUBPROVIDER - IPF	530,919	0	530,919	40.00
43.00	04300	NURSERY	133,494	0	133,494	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,290,722	0	1,290,722	50.00
51.00	05100	RECOVERY ROOM	121,172	0	121,172	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	430,965	0	430,965	52.00
53.00	05300	ANESTHESIOLOGY	27,113	0	27,113	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	741,177	0	741,177	54.00
56.00	05600	RADIOISOTOPE	226,639	0	226,639	56.00
57.00	05700	CT SCAN	63,103	0	63,103	57.00
58.00	05800	MRI	35,143	0	35,143	58.00
59.00	05900	CARDIAC CATHETERIZATION	54,137	0	54,137	59.00
60.00	06000	LABORATORY	177,507	0	177,507	60.00
65.00	06500	RESPIRATORY THERAPY	34,272	0	34,272	65.00
66.00	06600	PHYSICAL THERAPY	444,355	0	444,355	66.00
67.00	06700	OCCUPATIONAL THERAPY	30,161	0	30,161	67.00
68.00	06800	SPEECH PATHOLOGY	2,663	0	2,663	68.00
69.00	06900	ELECTROCARDIOLOGY	29,205	0	29,205	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	43,925	0	43,925	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	51,112	0	51,112	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,113	0	25,113	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	109,688	0	109,688	73.00
74.00	07400	RENAL DIALYSIS	2,094	0	2,094	74.00
76.00	03020	ANCILLARY	0	0	0	76.00
76.01	03950	WOUND CARE	79,458	0	79,458	76.01
76.97	07697	CARDIAC REHABILITATION	51,158	0	51,158	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	254,981	0	254,981	90.00
90.01	09001	ACI	1,642,817	0	1,642,817	90.01
91.00	09100	EMERGENCY	566,511	0	566,511	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,765,858	0	9,765,858	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	26,195	0	26,195	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
194.00	07950	FOUNDATION	14,771	0	14,771	194.00
194.01	07951	MARKETING	0	0	0	194.01
194.02	07952	PROF OFFICE BUILDINGS	277	0	277	194.02
194.03	07953	OP PHARMACY	35,648	0	35,648	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	1,220	0	1,220	194.04
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	9,843,969	0	9,843,969	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0304

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

Worksheet B-1

Date/Time Prepared:
3/20/2020 1:16 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	346,372					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		346,372				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	37,073,167			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,443	14,443	1,677,991	-27,676,384	91,796,554	5.00
7.00	00700	OPERATION OF PLANT	18,145	18,145	1,209,372	0	5,299,757	7.00
9.00	00900	HOUSEKEEPING	1,662	1,662	0	0	2,693,443	9.00
10.00	01000	DIETARY	8,745	8,745	0	0	319,407	10.00
11.00	01100	CAFETERIA	3,261	3,261	0	0	1,969,157	11.00
13.00	01300	NURSING ADMINISTRATION	5,446	5,446	1,278,984	0	1,850,814	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,773	5,773	169,409	0	277,923	14.00
15.00	01500	PHARMACY	2,287	2,287	1,571,629	0	2,058,174	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,401	3,401	13,591	0	841,151	16.00
17.00	01700	SOCIAL SERVICE	721	721	320,862	0	482,288	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	62,079	62,079	7,134,704	0	10,683,555	30.00
31.00	03100	INTENSIVE CARE UNIT	11,823	11,823	1,906,540	0	2,979,171	31.00
40.00	04000	SUBPROVIDER - IPF	14,727	14,727	2,132,367	0	3,074,877	40.00
43.00	04300	NURSERY	3,600	3,600	876,701	0	1,335,388	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	36,433	36,433	4,062,204	0	6,450,152	50.00
51.00	05100	RECOVERY ROOM	3,556	3,556	610,094	0	834,376	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,677	12,677	1,766,620	0	2,338,752	52.00
53.00	05300	ANESTHESIOLOGY	623	623	51,074	0	103,690	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,074	23,074	1,980,438	0	3,377,952	54.00
56.00	05600	RADIOISOTOPE	7,304	7,304	179,525	0	427,339	56.00
57.00	05700	CT SCAN	1,308	1,308	664,503	0	1,025,248	57.00
58.00	05800	MRI	920	920	295,229	0	393,444	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,125	1,125	519,724	0	660,813	59.00
60.00	06000	LABORATORY	3,967	3,967	1,516,349	0	2,946,194	60.00
65.00	06500	RESPIRATORY THERAPY	540	540	847,997	0	1,115,638	65.00
66.00	06600	PHYSICAL THERAPY	13,766	13,766	0	0	5,240,943	66.00
67.00	06700	OCCUPATIONAL THERAPY	954	954	0	0	206,939	67.00
68.00	06800	SPEECH PATHOLOGY	84	84	0	0	9,999	68.00
69.00	06900	ELECTROCARDIOLOGY	587	587	520,938	0	768,843	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,380	1,380	47,716	0	278,750	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	8,593,625	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,571,612	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	6,542,924	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	411,320	74.00
76.00	03020	ANCILLARY	0	0	0	0	0	76.00
76.01	03950	WOUND CARE	2,600	2,600	10,235	0	99,586	76.01
76.97	07697	CARDIAC REHABILITATION	1,621	1,621	138,357	0	214,230	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	7,638	7,638	1,190,073	0	1,938,530	90.00
90.01	09001	ACI	53,921	53,921	10,894	0	1,548,216	90.01
91.00	09100	EMERGENCY	14,652	14,652	3,837,514	0	5,262,134	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	344,843	344,843	36,541,634	-27,676,384	89,226,354	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	822	822	78,429	0	135,359	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	23,576	0	192.00
194.00	07950	FOUNDATION	473	473	16,873	0	42,629	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	PROF OFFICE BUILDINGS	0	0	0	0	61,082	194.02
194.03	07953	OP PHARMACY	234	234	308,385	0	2,058,356	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	127,846	0	272,774	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,654,370	3,189,599	4,347,386		27,676,384	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.211628	9.208594	0.117265		0.301497	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		410,474	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.004472	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0304

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

Worksheet B-1

Date/Time Prepared:
3/20/2020 1:16 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0304

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

Worksheet B-1

Date/Time Prepared:
3/20/2020 1:16 pm

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (TOTAL HOUR S)	NURSING ADMINISTRATION (TOTAL HOUR S)	
			7.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	313,784					7.00
9.00	00900	HOUSEKEEPING	1,662	312,122				9.00
10.00	01000	DIETARY	8,745	8,745	429,486			10.00
11.00	01100	CAFETERIA	3,261	3,261	331,835	1,636,868		11.00
13.00	01300	NURSING ADMINISTRATION	5,446	5,446	0	33,700	1,196,758	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,773	5,773	0	16,791	0	14.00
15.00	01500	PHARMACY	2,287	2,287	0	50,482	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,401	3,401	0	862	0	16.00
17.00	01700	SOCIAL SERVICE	721	721	0	9,305	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	62,079	62,079	65,879	435,322	435,322	30.00
31.00	03100	INTENSIVE CARE UNIT	11,823	11,823	8,479	86,226	86,226	31.00
40.00	04000	SUBPROVIDER - IPF	14,727	14,727	23,293	140,067	140,067	40.00
43.00	04300	NURSERY	3,600	3,600	0	44,330	44,330	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	36,433	36,433	0	146,299	146,299	50.00
51.00	05100	RECOVERY ROOM	3,556	3,556	0	22,895	22,895	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,677	12,677	0	89,325	89,325	52.00
53.00	05300	ANESTHESIOLOGY	623	623	0	2,260	2,260	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,074	23,074	0	82,716	0	54.00
56.00	05600	RADIOISOTOPE	7,304	7,304	0	9,772	0	56.00
57.00	05700	CT SCAN	1,308	1,308	0	27,249	0	57.00
58.00	05800	MRI	920	920	0	14,007	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,125	1,125	0	33,077	0	59.00
60.00	06000	LABORATORY	3,967	3,967	0	77,085	0	60.00
65.00	06500	RESPIRATORY THERAPY	540	540	0	46,348	0	65.00
66.00	06600	PHYSICAL THERAPY	13,766	13,766	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	954	954	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	84	84	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	587	587	0	22,351	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,380	1,380	0	1,215	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ANCILLARY	0	0	0	0	0	76.00
76.01	03950	WOUND CARE	2,600	2,600	0	236	0	76.01
76.97	07697	CARDIAC REHABILITATION	1,621	1,621	0	4,489	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	7,638	7,638	0	36,506	36,506	90.00
90.01	09001	ACI	53,921	53,921	0	0	0	90.01
91.00	09100	EMERGENCY	14,652	14,652	0	193,528	193,528	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	312,255	310,593	429,486	1,626,443	1,196,758	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	822	822	0	3,398	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FOUNDATION	473	473	0	1,200	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	PROF OFFICE BUILDINGS	0	0	0	0	0	194.02
194.03	07953	OP PHARMACY	234	234	0	5,827	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,897,618	3,542,042	707,181	3,217,933	2,656,597	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.982058	11.348261	1.646575	1.965909	2.219828	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	539,386	62,137	266,736	313,828	179,961	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.718972	0.199079	0.621059	0.191725	0.150374	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: 14-0304

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

Worksheet B-1

Date/Time Prepared:
3/20/2020 1:16 pm

Cost Center Description			CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	SOCIAL SERVICE (PATIENT DA YS)	
			14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,596,300				14.00
15.00	01500	PHARMACY	79,757	8,263,965			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	100	0	555,062,579		16.00
17.00	01700	SOCIAL SERVICE	90	0	0	30,751	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	403,252	4,321	28,225,817	17,077	30.00
31.00	03100	INTENSIVE CARE UNIT	354,962	600	5,238,282	2,198	31.00
40.00	04000	SUBPROVIDER - IPF	50,272	19	9,716,380	6,038	40.00
43.00	04300	NURSERY	22,419	139	2,956,816	2,499	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,529,982	30,744	59,746,559	0	50.00
51.00	05100	RECOVERY ROOM	27,648	207	5,928,743	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	178,134	2,372	8,301,300	0	52.00
53.00	05300	ANESTHESIOLOGY	104,222	147,550	16,532,090	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	91,647	2,207	42,730,589	0	54.00
56.00	05600	RADIOISOTOPE	8,363	0	5,636,806	0	56.00
57.00	05700	CT SCAN	91,725	1,402	60,522,838	0	57.00
58.00	05800	MRI	6,148	102	13,779,077	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	461,477	36	5,526,733	0	59.00
60.00	06000	LABORATORY	872,413	0	56,859,250	0	60.00
65.00	06500	RESPIRATORY THERAPY	88,625	0	11,199,853	0	65.00
66.00	06600	PHYSICAL THERAPY	1,447	0	16,845,187	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	1,516,061	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	356,220	0	68.00
69.00	06900	ELECTROCARDIOLOGY	11,106	194	17,823,109	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,207	0	2,646,833	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	497,700	0	11,828,259	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	24,189,613	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,396,692	56,043,041	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	1,319,459	0	74.00
76.00	03020	ANCILLARY	0	0	0	0	76.00
76.01	03950	WOUND CARE	4,216	1	7,154	0	76.01
76.97	07697	CARDIAC REHABILITATION	1,381	0	681,362	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	35,006	0	7,085,586	0	90.00
90.01	09001	ACI	0	0	111,740	0	90.01
91.00	09100	EMERGENCY	670,775	2,459	81,707,822	2,939	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,596,074	6,589,045	555,062,579	30,751	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	39	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	FOUNDATION	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	194.01
194.02	07952	PROF OFFICE BUILDINGS	187	0	0	0	194.02
194.03	07953	OP PHARMACY	0	1,674,920	0	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	587,142	2,859,624	1,209,814	670,026	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.068302	0.346035	0.002180	21.788755	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	179,605	89,932	107,109	25,817	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.020893	0.010882	0.000193	0.839550	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0304

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

Worksheet B-1

Date/Time Prepared:
3/20/2020 1:16 pm

Cost Center Description			CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	SOCIAL SERVICE (PATIENT DA YS)	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	14.00	15.00	16.00	17.00	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0304

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
3/20/2020 1:16 pm

			Title XVIII	Hospital	PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,367,002	18,367,002	0	18,367,002 30.00
31.00	03100	INTENSIVE CARE UNIT	4,730,090	4,730,090	0	4,730,090 31.00
40.00	04000	SUBPROVIDER - IPF	5,273,621	5,273,621	0	5,273,621 40.00
43.00	04300	NURSERY	2,106,021	2,106,021	0	2,106,021 43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,671,834	10,671,834	0	10,671,834 50.00
51.00	05100	RECOVERY ROOM	1,315,177	1,315,177	0	1,315,177 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,871,384	3,871,384	0	3,871,384 52.00
53.00	05300	ANESTHESIOLOGY	259,393	259,393	0	259,393 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,428,247	5,428,247	0	5,428,247 54.00
56.00	05600	RADIOISOTOPE	831,695	831,695	0	831,695 56.00
57.00	05700	CT SCAN	1,570,213	1,570,213	0	1,570,213 57.00
58.00	05800	MRI	600,758	600,758	0	600,758 58.00
59.00	05900	CARDIAC CATHETERIZATION	1,000,149	1,000,149	0	1,000,149 59.00
60.00	06000	LABORATORY	4,301,768	4,301,768	0	4,301,768 60.00
65.00	06500	RESPIRATORY THERAPY	1,591,583	1,591,583	0	1,591,583 65.00
66.00	06600	PHYSICAL THERAPY	7,316,719	7,316,719	0	7,316,719 66.00
67.00	06700	OCCUPATIONAL THERAPY	304,432	304,432	0	304,432 67.00
68.00	06800	SPEECH PATHOLOGY	16,590	16,590	0	16,590 68.00
69.00	06900	ELECTROCARDIOLOGY	1,103,831	1,103,831	0	1,103,831 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	417,166	417,166	0	417,166 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,244,357	11,244,357	0	11,244,357 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,002,672	6,002,672	0	6,002,672 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,851,252	10,851,252	0	10,851,252 73.00
74.00	07400	RENAL DIALYSIS	538,208	538,208	0	538,208 74.00
76.00	03020	ANCILLARY	0	0	0	0 76.00
76.01	03950	WOUND CARE	217,037	217,037	0	217,037 76.01
76.97	07697	CARDIAC REHABILITATION	343,253	343,253	0	343,253 76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,948,210	2,948,210	0	2,948,210 90.00
90.01	09001	ACI	3,812,447	3,812,447	0	3,812,447 90.01
91.00	09100	EMERGENCY	8,435,668	8,435,668	0	8,435,668 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,696,885	2,696,885	0	2,696,885 92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
200.00		Subtotal (see instructions)	118,173,662	118,173,662	0	118,173,662 200.00
201.00		Less Observation Beds	2,696,885	2,696,885	0	2,696,885 201.00
202.00		Total (see instructions)	115,476,777	115,476,777	0	115,476,777 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0304

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
3/20/2020 1:16 pm

			Title XVIII			Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						9.00	10.00	
30.00	03000	ADULTS & PEDIATRICS	21,617,447		21,617,447			30.00
31.00	03100	INTENSIVE CARE UNIT	5,238,282		5,238,282			31.00
40.00	04000	SUBPROVIDER - IPF	9,716,380		9,716,380			40.00
43.00	04300	NURSERY	2,956,816		2,956,816			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,544,801	48,201,758	59,746,559	0.178618	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,818,717	4,110,026	5,928,743	0.221831	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,301,763	999,537	8,301,300	0.466359	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	4,548,223	11,983,867	16,532,090	0.015690	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,005,355	34,725,234	42,730,589	0.127034	0.000000	54.00
56.00	05600	RADIOISOTOPE	1,304,190	4,332,616	5,636,806	0.147547	0.000000	56.00
57.00	05700	CT SCAN	15,567,676	44,955,162	60,522,838	0.025944	0.000000	57.00
58.00	05800	MRI	2,511,695	11,267,382	13,779,077	0.043599	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,585,451	1,941,282	5,526,733	0.182051	0.000000	59.00
60.00	06000	LABORATORY	26,718,853	30,140,397	56,859,250	0.075656	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	9,914,613	1,285,240	11,199,853	0.142107	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,130,173	14,715,014	16,845,187	0.434351	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,107,634	408,427	1,516,061	0.200805	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	260,503	95,717	356,220	0.046572	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	6,108,322	11,714,787	17,823,109	0.061933	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	162,244	2,484,589	2,646,833	0.157609	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,241,229	7,587,030	11,828,259	0.950635	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,107,919	19,081,694	24,189,613	0.248151	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,418,544	33,624,497	56,043,041	0.193624	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,313,519	5,940	1,319,459	0.407901	0.000000	74.00
76.00	03020	ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03950	WOUND CARE	0	7,154	7,154	30.337853	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	7,182	674,180	681,362	0.503775	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	52,246	7,033,340	7,085,586	0.416086	0.000000	90.00
90.01	09001	ACI	0	111,740	111,740	34.118910	0.000000	90.01
91.00	09100	EMERGENCY	16,612,976	65,094,846	81,707,822	0.103242	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,372,822	5,235,548	6,608,370	0.408101	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	193,245,575	361,817,004	555,062,579			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	193,245,575	361,817,004	555,062,579			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0304

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
3/20/2020 1:16 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.178618		50.00
51.00	05100	RECOVERY ROOM	0.221831		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.466359		52.00
53.00	05300	ANESTHESIOLOGY	0.015690		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127034		54.00
56.00	05600	RADIOISOTOPE	0.147547		56.00
57.00	05700	CT SCAN	0.025944		57.00
58.00	05800	MRI	0.043599		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.182051		59.00
60.00	06000	LABORATORY	0.075656		60.00
65.00	06500	RESPIRATORY THERAPY	0.142107		65.00
66.00	06600	PHYSICAL THERAPY	0.434351		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.200805		67.00
68.00	06800	SPEECH PATHOLOGY	0.046572		68.00
69.00	06900	ELECTROCARDIOLOGY	0.061933		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.157609		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.950635		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.248151		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.193624		73.00
74.00	07400	RENAL DIALYSIS	0.407901		74.00
76.00	03020	ANCILLARY	0.000000		76.00
76.01	03950	WOUND CARE	30.337853		76.01
76.97	07697	CARDIAC REHABILITATION	0.503775		76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.416086		90.00
90.01	09001	ACI	34.118910		90.01
91.00	09100	EMERGENCY	0.103242		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.408101		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
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: 14-0304

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
3/20/2020 1:16 pm

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	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	18,367,002		18,367,002	0	18,367,002	30.00
31.00	03100	INTENSIVE CARE UNIT	4,730,090		4,730,090	0	4,730,090	31.00
40.00	04000	SUBPROVIDER - IPF	5,273,621		5,273,621	0	5,273,621	40.00
43.00	04300	NURSERY	2,106,021		2,106,021	0	2,106,021	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,671,834		10,671,834	0	10,671,834	50.00
51.00	05100	RECOVERY ROOM	1,315,177		1,315,177	0	1,315,177	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,871,384		3,871,384	0	3,871,384	52.00
53.00	05300	ANESTHESIOLOGY	259,393		259,393	0	259,393	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,428,247		5,428,247	0	5,428,247	54.00
56.00	05600	RADIOISOTOPE	831,695		831,695	0	831,695	56.00
57.00	05700	CT SCAN	1,570,213		1,570,213	0	1,570,213	57.00
58.00	05800	MRI	600,758		600,758	0	600,758	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,006,149		1,006,149	0	1,006,149	59.00
60.00	06000	LABORATORY	4,301,768		4,301,768	0	4,301,768	60.00
65.00	06500	RESPIRATORY THERAPY	1,591,583	0	1,591,583	0	1,591,583	65.00
66.00	06600	PHYSICAL THERAPY	7,316,719	0	7,316,719	0	7,316,719	66.00
67.00	06700	OCCUPATIONAL THERAPY	304,432	0	304,432	0	304,432	67.00
68.00	06800	SPEECH PATHOLOGY	16,590	0	16,590	0	16,590	68.00
69.00	06900	ELECTROCARDIOLOGY	1,103,831		1,103,831	0	1,103,831	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	417,166		417,166	0	417,166	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,244,357		11,244,357	0	11,244,357	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,002,672		6,002,672	0	6,002,672	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,851,252		10,851,252	0	10,851,252	73.00
74.00	07400	RENAL DIALYSIS	538,208		538,208	0	538,208	74.00
76.00	03020	ANCILLARY	0		0	0	0	76.00
76.01	03950	WOUND CARE	217,037		217,037	0	217,037	76.01
76.97	07697	CARDIAC REHABILITATION	343,253		343,253	0	343,253	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,948,210		2,948,210	0	2,948,210	90.00
90.01	09001	ACI	3,812,447		3,812,447	0	3,812,447	90.01
91.00	09100	EMERGENCY	8,435,668		8,435,668	0	8,435,668	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,696,885		2,696,885		2,696,885	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	118,173,662	0	118,173,662	0	118,173,662	200.00
201.00		Less Observation Beds	2,696,885		2,696,885		2,696,885	201.00
202.00		Total (see instructions)	115,476,777	0	115,476,777	0	115,476,777	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0304

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
3/20/2020 1:16 pm

			Title XIX			Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	21,617,447		21,617,447			30.00
31.00	03100	INTENSIVE CARE UNIT	5,238,282		5,238,282			31.00
40.00	04000	SUBPROVIDER - IPF	9,716,380		9,716,380			40.00
43.00	04300	NURSERY	2,956,816		2,956,816			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	11,544,801	48,201,758	59,746,559	0.178618	0.178618	50.00
51.00	05100	RECOVERY ROOM	1,818,717	4,110,026	5,928,743	0.221831	0.221831	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,301,763	999,537	8,301,300	0.466359	0.466359	52.00
53.00	05300	ANESTHESIOLOGY	4,548,223	11,983,867	16,532,090	0.015690	0.015690	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,005,355	34,725,234	42,730,589	0.127034	0.127034	54.00
56.00	05600	RADIOISOTOPE	1,304,190	4,332,616	5,636,806	0.147547	0.147547	56.00
57.00	05700	CT SCAN	15,567,676	44,955,162	60,522,838	0.025944	0.025944	57.00
58.00	05800	MRI	2,511,695	11,267,382	13,779,077	0.043599	0.043599	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,585,451	1,941,282	5,526,733	0.182051	0.182051	59.00
60.00	06000	LABORATORY	26,718,853	30,140,397	56,859,250	0.075656	0.075656	60.00
65.00	06500	RESPIRATORY THERAPY	9,914,613	1,285,240	11,199,853	0.142107	0.142107	65.00
66.00	06600	PHYSICAL THERAPY	2,130,173	14,715,014	16,845,187	0.434351	0.434351	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,107,634	408,427	1,516,061	0.200805	0.200805	67.00
68.00	06800	SPEECH PATHOLOGY	260,503	95,717	356,220	0.046572	0.046572	68.00
69.00	06900	ELECTROCARDIOLOGY	6,108,322	11,714,787	17,823,109	0.061933	0.061933	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	162,244	2,484,589	2,646,833	0.157609	0.157609	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,241,229	7,587,030	11,828,259	0.950635	0.950635	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,107,919	19,081,694	24,189,613	0.248151	0.248151	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,418,544	33,624,497	56,043,041	0.193624	0.193624	73.00
74.00	07400	RENAL DIALYSIS	1,313,519	5,940	1,319,459	0.407901	0.407901	74.00
76.00	03020	ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03950	WOUND CARE	0	7,154	7,154	30.337853	30.337853	76.01
76.97	07697	CARDIAC REHABILITATION	7,182	674,180	681,362	0.503775	0.503775	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	52,246	7,033,340	7,085,586	0.416086	0.416086	90.00
90.01	09001	ACI	0	111,740	111,740	34.118910	34.118910	90.01
91.00	09100	EMERGENCY	16,612,976	65,094,846	81,707,822	0.103242	0.103242	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,372,822	5,235,548	6,608,370	0.408101	0.408101	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	193,245,575	361,817,004	555,062,579			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	193,245,575	361,817,004	555,062,579			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0304

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
3/20/2020 1:16 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
76.00	03020	ANCILLARY	0.000000			76.00
76.01	03950	WOUND CARE	0.000000			76.01
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
90.01	09001	ACI	0.000000			90.01
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
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: 14-0304

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part I
Date/Time Prepared:
3/20/2020 1:16 pm

Title XVIII			Hospital		PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,149,199	0	2,149,199	20,016	107.37	30.00
31.00	INTENSIVE CARE UNIT	417,055		417,055	2,198	189.74	31.00
40.00	SUBPROVIDER - IPF	530,919	0	530,919	6,038	87.93	40.00
43.00	NURSERY	133,494		133,494	2,499	53.42	43.00
200.00	Total (lines 30 through 199)	3,230,667		3,230,667	30,751		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	5,581	599,232				
31.00	INTENSIVE CARE UNIT	830	157,484				
40.00	SUBPROVIDER - IPF	4,411	387,859				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	10,822	1,144,575				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0304		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part II Date/Time Prepared: 3/20/2020 1:16 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description				Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
				1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		1,290,722	59,746,559	0.021603	3,225,881	69,689	50.00
51.00	05100	RECOVERY ROOM		121,172	5,928,743	0.020438	427,781	8,743	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		430,965	8,301,300	0.051915	10,092	524	52.00
53.00	05300	ANESTHESIOLOGY		27,113	16,532,090	0.001640	969,938	1,591	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		741,177	42,730,589	0.017345	2,909,789	50,470	54.00
56.00	05600	RADIOISOTOPE		226,639	5,636,806	0.040207	507,206	20,393	56.00
57.00	05700	CT SCAN		63,103	60,522,838	0.001043	4,786,354	4,992	57.00
58.00	05800	MRI		35,143	13,779,077	0.002550	815,004	2,078	58.00
59.00	05900	CARDIAC CATHETERIZATION		54,137	5,526,733	0.009795	1,100,451	10,779	59.00
60.00	06000	LABORATORY		177,507	56,859,250	0.003122	8,969,106	28,002	60.00
65.00	06500	RESPIRATORY THERAPY		34,272	11,199,853	0.003060	3,944,862	12,071	65.00
66.00	06600	PHYSICAL THERAPY		444,355	16,845,187	0.026379	848,243	22,376	66.00
67.00	06700	OCCUPATIONAL THERAPY		30,161	1,516,061	0.019894	479,876	9,547	67.00
68.00	06800	SPEECH PATHOLOGY		2,663	356,220	0.007476	122,267	914	68.00
69.00	06900	ELECTROCARDIOLOGY		29,205	17,823,109	0.001639	2,438,113	3,996	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		43,925	2,646,833	0.016595	77,120	1,280	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		51,112	11,828,259	0.004321	956,442	4,133	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		25,113	24,189,613	0.001038	1,892,096	1,964	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		109,688	56,043,041	0.001957	6,827,827	13,362	73.00
74.00	07400	RENAL DIALYSIS		2,094	1,319,459	0.001587	754,766	1,198	74.00
76.00	03020	ANCILLARY		0	0	0.000000	0	0	76.00
76.01	03950	WOUND CARE		79,458	7,154	11.106793	0	0	76.01
76.97	07697	CARDIAC REHABILITATION		51,158	681,362	0.075082	1,729	130	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		254,981	7,085,586	0.035986	3,107	112	90.00
90.01	09001	ACI		1,642,817	111,740	14.702139	0	0	90.01
91.00	09100	EMERGENCY		566,511	81,707,822	0.006933	5,274,636	36,569	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		315,573	6,608,370	0.047754	474,244	22,647	92.00
200.00		Total (lines 50 through 199)		6,850,764	515,533,654		47,816,930	327,560	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0304		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part III Date/Time Prepared: 3/20/2020 1:16 pm		
					Title XVIII		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	0	40.00	
43.00	04300	NURSERY	0	0	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	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	20,016	0.00	5,581			30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	2,198	0.00	830			31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	6,038	0.00	4,411			40.00	
43.00	04300	NURSERY	0	0	2,499	0.00	0			43.00	
200.00		Total (lines 30 through 199)	0	0	30,751		10,822			200.00	
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0							30.00	
31.00	03100	INTENSIVE CARE UNIT	0							31.00	
40.00	04000	SUBPROVIDER - IPF	0							40.00	
43.00	04300	NURSERY	0							43.00	
200.00		Total (lines 30 through 199)	0							200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0304

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
3/20/2020 1:16 pm

Cost Center Description		Title XVIII			Hospital		PPS
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03020	ANCILLARY	0	0	0	0	76.00
76.01	03950	WOUND CARE	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	ACI	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0304		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 3/20/2020 1:16 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	59,746,559	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	5,928,743	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	8,301,300	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	16,532,090	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	42,730,589	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	5,636,806	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	60,522,838	0.000000	57.00
58.00	05800	MRI	0	0	0	13,779,077	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	5,526,733	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	56,859,250	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,199,853	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	16,845,187	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,516,061	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	356,220	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	17,823,109	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,646,833	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	11,828,259	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	24,189,613	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	56,043,041	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,319,459	0.000000	74.00
76.00	03020	ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03950	WOUND CARE	0	0	0	7,154	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	681,362	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	7,085,586	0.000000	90.00
90.01	09001	ACI	0	0	0	111,740	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	81,707,822	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	6,608,370	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	515,533,654		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0304

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
3/20/2020 1:16 pm

Cost Center Description			Title XVIII		Hospital		PPS
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
			9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	3,225,881	0	10,724,259	0
51.00	05100	RECOVERY ROOM	0.000000	427,781	0	623,930	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	10,092	0	0	0
53.00	05300	ANESTHESIOLOGY	0.000000	969,938	0	2,476,645	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,909,789	0	3,914,951	0
56.00	05600	RADIOISOTOPE	0.000000	507,206	0	1,274,098	0
57.00	05700	CT SCAN	0.000000	4,786,354	0	7,209,455	0
58.00	05800	MRI	0.000000	815,004	0	1,822,074	0
59.00	05900	CARDIAC CATHETERIZATION	0.000000	1,100,451	0	709,279	0
60.00	06000	LABORATORY	0.000000	8,969,106	0	3,091,203	0
65.00	06500	RESPIRATORY THERAPY	0.000000	3,944,862	0	303,577	0
66.00	06600	PHYSICAL THERAPY	0.000000	848,243	0	44,901	0
67.00	06700	OCCUPATIONAL THERAPY	0.000000	479,876	0	23,473	0
68.00	06800	SPEECH PATHOLOGY	0.000000	122,267	0	4,177	0
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,438,113	0	2,163,916	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	77,120	0	508,598	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	956,442	0	1,952,145	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,892,096	0	6,168,604	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	6,827,827	0	8,959,103	0
74.00	07400	RENAL DIALYSIS	0.000000	754,766	0	0	0
76.00	03020	ANCILLARY	0.000000	0	0	0	0
76.01	03950	WOUND CARE	0.000000	0	0	1,275	0
76.97	07697	CARDIAC REHABILITATION	0.000000	1,729	0	305,769	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	3,107	0	837,118	0
90.01	09001	ACI	0.000000	0	0	101,135	0
91.00	09100	EMERGENCY	0.000000	5,274,636	0	6,043,429	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	474,244	0	1,131,740	0
200.00		Total (lines 50 through 199)		47,816,930	0	60,394,854	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0304		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part V Date/Time Prepared: 3/20/2020 1:16 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.178618	10,724,259	0	0	1,915,546	50.00
51.00	05100	RECOVERY ROOM	0.221831	623,930	0	0	138,407	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.466359	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.015690	2,476,645	0	0	38,859	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127034	3,914,951	0	0	497,332	54.00
56.00	05600	RADIOISOTOPE	0.147547	1,274,098	0	0	187,989	56.00
57.00	05700	CT SCAN	0.025944	7,209,455	0	0	187,042	57.00
58.00	05800	MRI	0.043599	1,822,074	0	0	79,441	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.182051	709,279	0	0	129,125	59.00
60.00	06000	LABORATORY	0.075656	3,091,203	0	0	233,868	60.00
65.00	06500	RESPIRATORY THERAPY	0.142107	303,577	0	0	43,140	65.00
66.00	06600	PHYSICAL THERAPY	0.434351	44,901	0	0	19,503	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.200805	23,473	0	0	4,713	67.00
68.00	06800	SPEECH PATHOLOGY	0.046572	4,177	0	0	195	68.00
69.00	06900	ELECTROCARDIOLOGY	0.061933	2,163,916	0	0	134,018	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.157609	508,598	0	0	80,160	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.950635	1,952,145	0	0	1,855,777	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.248151	6,168,604	0	0	1,530,745	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.193624	8,959,103	0	48,049	1,734,697	73.00
74.00	07400	RENAL DIALYSIS	0.407901	0	0	0	0	74.00
76.00	03020	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03950	WOUND CARE	30.337853	1,275	0	0	38,681	76.01
76.97	07697	CARDIAC REHABILITATION	0.503775	305,769	0	0	154,039	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.416086	837,118	0	0	348,313	90.00
90.01	09001	ACI	34.118910	101,135	0	0	3,450,616	90.01
91.00	09100	EMERGENCY	0.103242	6,043,429	0	0	623,936	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.408101	1,131,740	0	0	461,864	92.00
200.00		Subtotal (see instructions)		60,394,854	0	48,049	13,888,006	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0		201.00
201.00		Only Charges						
202.00		Net Charges (line 200 - line 201)		60,394,854	0	48,049	13,888,006	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0304

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
3/20/2020 1:16 pm

			Title XVIII		Hospital	PPS
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,303		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	ANCILLARY	0	0		76.00
76.01	03950	WOUND CARE	0	0		76.01
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0		90.00
90.01	09001	ACI	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	9,303		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	9,303		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0304

Period:

Worksheet D

Component CCN: 14-S304

From 01/01/2019
To 12/31/2019Part II
Date/Time Prepared:
3/20/2020 1:16 pm

				Title XVIII		Subprovider - IPF	PPS
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,290,722	59,746,559	0.021603	0	0 50.00
51.00	05100	RECOVERY ROOM	121,172	5,928,743	0.020438	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	430,965	8,301,300	0.051915	0	0 52.00
53.00	05300	ANESTHESIOLOGY	27,113	16,532,090	0.001640	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	741,177	42,730,589	0.017345	124,618	2,161 54.00
56.00	05600	RADIOISOTOPE	226,639	5,636,806	0.040207	8,275	333 56.00
57.00	05700	CT SCAN	63,103	60,522,838	0.001043	267,048	279 57.00
58.00	05800	MRI	35,143	13,779,077	0.002550	19,416	50 58.00
59.00	05900	CARDIAC CATHETERIZATION	54,137	5,526,733	0.009795	0	0 59.00
60.00	06000	LABORATORY	177,507	56,859,250	0.003122	917,845	2,866 60.00
65.00	06500	RESPIRATORY THERAPY	34,272	11,199,853	0.003060	108,343	332 65.00
66.00	06600	PHYSICAL THERAPY	444,355	16,845,187	0.026379	252,707	6,666 66.00
67.00	06700	OCCUPATIONAL THERAPY	30,161	1,516,061	0.019894	84,171	1,674 67.00
68.00	06800	SPEECH PATHOLOGY	2,663	356,220	0.007476	14,937	112 68.00
69.00	06900	ELECTROCARDIOLOGY	29,205	17,823,109	0.001639	90,426	148 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	43,925	2,646,833	0.016595	2,540	42 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	51,112	11,828,259	0.004321	2,708	12 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,113	24,189,613	0.001038	1,080	1 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	109,688	56,043,041	0.001957	1,029,225	2,014 73.00
74.00	07400	RENAL DIALYSIS	2,094	1,319,459	0.001587	23,452	37 74.00
76.00	03020	ANCILLARY	0	0	0.000000	0	0 76.00
76.01	03950	WOUND CARE	79,458	7,154	11.106793	0	0 76.01
76.97	07697	CARDIAC REHABILITATION	51,158	681,362	0.075082	0	0 76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	254,981	7,085,586	0.035986	0	0 90.00
90.01	09001	ACI	1,642,817	111,740	14.702139	0	0 90.01
91.00	09100	EMERGENCY	566,511	81,707,822	0.006933	456,537	3,165 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,608,370	0.000000	35,232	0 92.00
200.00		Total (lines 50 through 199)	6,535,191	515,533,654		3,438,560	19,892 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0304 Component CCN: 14-S304		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 3/20/2020 1:16 pm	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ANCILLARY	0	0	0	0	0	76.00
76.01	03950	WOUND CARE	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	ACI	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0304 Component CCN: 14-S304		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 3/20/2020 1:16 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	59,746,559	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	5,928,743	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	8,301,300	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	16,532,090	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	42,730,589	0.000000	54.00
56.00	05600	RADIOISOTOPE		0	0	0	5,636,806	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	60,522,838	0.000000	57.00
58.00	05800	MRI		0	0	0	13,779,077	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	5,526,733	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	56,859,250	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	11,199,853	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	16,845,187	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	1,516,061	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	356,220	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	17,823,109	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	2,646,833	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	11,828,259	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	24,189,613	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	56,043,041	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	1,319,459	0.000000	74.00
76.00	03020	ANCILLARY		0	0	0	0	0.000000	76.00
76.01	03950	WOUND CARE		0	0	0	7,154	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION		0	0	0	681,362	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	7,085,586	0.000000	90.00
90.01	09001	ACI		0	0	0	111,740	0.000000	90.01
91.00	09100	EMERGENCY		0	0	0	81,707,822	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	6,608,370	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	515,533,654		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0304 Component CCN: 14-S304		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 3/20/2020 1:16 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	124,618	0	490	0	54.00
56.00	05600	RADIOISOTOPE		0.000000	8,275	0	0	0	56.00
57.00	05700	CT SCAN		0.000000	267,048	0	2,400	0	57.00
58.00	05800	MRI		0.000000	19,416	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	917,845	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0.000000	108,343	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	252,707	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	84,171	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	14,937	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	90,426	0	690	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	2,540	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	2,708	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	1,080	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	1,029,225	0	5,838	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	23,452	0	0	0	74.00
76.00	03020	ANCILLARY		0.000000	0	0	0	0	76.00
76.01	03950	WOUND CARE		0.000000	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
90.01	09001	ACI		0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY		0.000000	456,537	0	1,836	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	35,232	0	0	0	92.00
200.00		Total (lines 50 through 199)			3,438,560	0	11,254	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0304 Component CCN: 14-S304		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part V Date/Time Prepared: 3/20/2020 1:16 pm	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	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	0.178618	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.221831	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.466359	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.015690	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127034	490	0	0	62	54.00
56.00	05600	RADIOISOTOPE	0.147547	0	0	0	0	56.00
57.00	05700	CT SCAN	0.025944	2,400	0	0	62	57.00
58.00	05800	MRI	0.043599	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.182051	0	0	0	0	59.00
60.00	06000	LABORATORY	0.075656	0	0	1,525	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.142107	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.434351	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.200805	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.046572	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.061933	690	0	0	43	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.157609	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.950635	0	0	19	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.248151	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.193624	5,838	0	995	1,130	73.00
74.00	07400	RENAL DIALYSIS	0.407901	0	0	0	0	74.00
76.00	03020	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03950	WOUND CARE	30.337853	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.503775	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.416086	0	0	0	0	90.00
90.01	09001	ACI	34.118910	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.103242	1,836	0	7,956	190	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.408101	0	0	279	0	92.00
200.00		Subtotal (see instructions)		11,254	0	10,774	1,487	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		11,254	0	10,774	1,487	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0304 Component CCN: 14-S304		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part V Date/Time Prepared: 3/20/2020 1:16 pm		
			Title XVIII		Subprovider - IPF		PPS		
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0					50.00
51.00	05100	RECOVERY ROOM	0	0					51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0					52.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
56.00	05600	RADIOISOTOPE	0	0					56.00
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	115					60.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
68.00	06800	SPEECH PATHOLOGY	0	0					68.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0					70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	18					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	193					73.00
74.00	07400	RENAL DIALYSIS	0	0					74.00
76.00	03020	ANCILLARY	0	0					76.00
76.01	03950	WOUND CARE	0	0					76.01
76.97	07697	CARDIAC REHABILITATION	0	0					76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0					90.00
90.01	09001	ACI	0	0					90.01
91.00	09100	EMERGENCY	0	821					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	114					92.00
200.00		Subtotal (see instructions)	0	1,261					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	1,261					202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0304 Component CCN: 14-S304		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part II Date/Time Prepared: 3/20/2020 1:16 pm	
				Title XIX		Subprovider - IPF		TEFRA	
Cost Center Description				Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
				1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		1,290,722	59,746,559	0.021603	0	0	50.00
51.00	05100	RECOVERY ROOM		121,172	5,928,743	0.020438	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		430,965	8,301,300	0.051915	0	0	52.00
53.00	05300	ANESTHESIOLOGY		27,113	16,532,090	0.001640	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		741,177	42,730,589	0.017345	0	0	54.00
56.00	05600	RADIOISOTOPE		226,639	5,636,806	0.040207	0	0	56.00
57.00	05700	CT SCAN		63,103	60,522,838	0.001043	0	0	57.00
58.00	05800	MRI		35,143	13,779,077	0.002550	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		54,137	5,526,733	0.009795	0	0	59.00
60.00	06000	LABORATORY		177,507	56,859,250	0.003122	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		34,272	11,199,853	0.003060	0	0	65.00
66.00	06600	PHYSICAL THERAPY		444,355	16,845,187	0.026379	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		30,161	1,516,061	0.019894	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		2,663	356,220	0.007476	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		29,205	17,823,109	0.001639	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		43,925	2,646,833	0.016595	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		51,112	11,828,259	0.004321	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		25,113	24,189,613	0.001038	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		109,688	56,043,041	0.001957	0	0	73.00
74.00	07400	RENAL DIALYSIS		2,094	1,319,459	0.001587	0	0	74.00
76.00	03020	ANCILLARY		0	0	0.000000	0	0	76.00
76.01	03950	WOUND CARE		79,458	7,154	11.106793	0	0	76.01
76.97	07697	CARDIAC REHABILITATION		51,158	681,362	0.075082	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		254,981	7,085,586	0.035986	0	0	90.00
90.01	09001	ACI		1,642,817	111,740	14.702139	0	0	90.01
91.00	09100	EMERGENCY		566,511	81,707,822	0.006933	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	6,608,370	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)		6,535,191	515,533,654		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0304 Component CCN: 14-S304		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 3/20/2020 1:16 pm	
			Title XIX		Subprovider - IPF		TEFRA	
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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ANCILLARY	0	0	0	0	0	76.00
76.01	03950	WOUND CARE	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	ACI	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0304 Component CCN: 14-S304		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 3/20/2020 1:16 pm	
				Title XIX		Subprovider - IPF		TEFRA	
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	59,746,559	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	5,928,743	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	8,301,300	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	16,532,090	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	42,730,589	0.000000	54.00
56.00	05600	RADIOISOTOPE		0	0	0	5,636,806	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	60,522,838	0.000000	57.00
58.00	05800	MRI		0	0	0	13,779,077	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	5,526,733	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	56,859,250	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	11,199,853	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	16,845,187	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	1,516,061	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	356,220	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	17,823,109	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	2,646,833	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	11,828,259	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	24,189,613	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	56,043,041	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	1,319,459	0.000000	74.00
76.00	03020	ANCILLARY		0	0	0	0	0.000000	76.00
76.01	03950	WOUND CARE		0	0	0	7,154	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION		0	0	0	681,362	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	7,085,586	0.000000	90.00
90.01	09001	ACI		0	0	0	111,740	0.000000	90.01
91.00	09100	EMERGENCY		0	0	0	81,707,822	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	6,608,370	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	515,533,654		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0304 Component CCN: 14-S304		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 3/20/2020 1:16 pm	
				Title XIX		Subprovider - IPF		TEFRA	
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
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE		0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN		0.000000	0	0	0	0	57.00
58.00	05800	MRI		0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	0	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	0	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		0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0	74.00
76.00	03020	ANCILLARY		0.000000	0	0	0	0	76.00
76.01	03950	WOUND CARE		0.000000	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
90.01	09001	ACI		0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY		0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0304	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 3/20/2020 1:16 pm	
Cost Center Description		Title XVIII	Hospital	PPS	
				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			20,016	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			20,016	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)			17,077	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)			5,581	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)			18,367,002	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)			18,367,002	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)			18,367,002	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)			917.62	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			5,121,237	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			5,121,237	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0304

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

Worksheet D-1

Date/Time Prepared:
3/20/2020 1:16 pm

Cost Center Description		Title XVIII		Hospital		PPS
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,730,090	2,198	2,152.00	830	1,786,160
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					7,117,273
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					14,024,670
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					756,716
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					327,560
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,084,276
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					12,940,394
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					2,939
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					917.62
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,696,885

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0304

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

Worksheet D-1

Date/Time Prepared:
3/20/2020 1:16 pm

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	2,149,199	18,367,002	0.117014	2,696,885	315,573	90.00
91.00 Nursing School cost	0	18,367,002	0.000000	2,696,885	0	91.00
92.00 Allied health cost	0	18,367,002	0.000000	2,696,885	0	92.00
93.00 All other Medical Education	0	18,367,002	0.000000	2,696,885	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0304 Component CCN: 14-S304	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 3/20/2020 1:16 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,038	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,038	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)		6,038	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)		4,411	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)		5,273,621	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)		5,273,621	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)		5,273,621	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)		873.41	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,852,612	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		3,852,612	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0304 Component CCN: 14-S304	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 3/20/2020 1:16 pm
			Title XVIII	Subprovider - IPF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0
44.00 CORONARY CARE UNIT					
45.00 BURN INTENSIVE CARE UNIT					
46.00 SURGICAL INTENSIVE CARE UNIT					
47.00 OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					516,228
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,368,840
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					387,859
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					19,892
52.00 Total Program excludable cost (sum of lines 50 and 51)					407,751
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,961,089
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					
72.00 Program routine service cost (line 9 x line 71)					
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					
76.00 Per diem capital-related costs (line 75 ÷ line 2)					
77.00 Program capital-related costs (line 9 x line 76)					
78.00 Inpatient routine service cost (line 74 minus line 77)					
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					
81.00 Inpatient routine service cost per diem limitation					
82.00 Inpatient routine service cost limitation (line 9 x line 81)					
83.00 Reasonable inpatient routine service costs (see instructions)					
84.00 Program inpatient ancillary services (see instructions)					
85.00 Utilization review - physician compensation (see instructions)					
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					0
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0304 Component CCN: 14-S304		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 3/20/2020 1:16 pm
			Title XVIII		Subprovider - IPF		PPS
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	530,919	5,273,621	0.100674	0	0	90.00
91.00	Nursing School cost	0	5,273,621	0.000000	0	0	91.00
92.00	Allied health cost	0	5,273,621	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,273,621	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0304 Component CCN: 14-S304	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 3/20/2020 1:16 pm
		Title XIX	Subprovider - IPF	TEFRA
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)		6,038	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,038	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)		6,038	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)		0	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)		2,499	15.00
16.00	Nursery days (title V or XIX only)		498	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)		5,273,621	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)		5,273,621	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)		5,273,621	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)		873.41	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		0	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)		0	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0304 Component CCN: 14-S304	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 3/20/2020 1:16 pm	
				Title XIX	Subprovider - IPF	TEFRA	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	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)					0	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: 14-0304 Component CCN: 14-S304		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 3/20/2020 1:16 pm	
				Title XIX		Subprovider - IPF		TEFRA	
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	5,273,621	0.000000	0	0	90.00
91.00	Nursing School cost			0	5,273,621	0.000000	0	0	91.00
92.00	Allied health cost			0	5,273,621	0.000000	0	0	92.00
93.00	All other Medical Education			0	5,273,621	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0304	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 3/20/2020 1:16 pm	
			Title XVIII	Hospital	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		7,776,203		30.00
31.00	03100	INTENSIVE CARE UNIT		2,015,442		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.178618	3,225,881	576,200	50.00
51.00	05100	RECOVERY ROOM	0.221831	427,781	94,895	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.466359	10,092	4,706	52.00
53.00	05300	ANESTHESIOLOGY	0.015690	969,938	15,218	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127034	2,909,789	369,642	54.00
56.00	05600	RADIOISOTOPE	0.147547	507,206	74,837	56.00
57.00	05700	CT SCAN	0.025944	4,786,354	124,177	57.00
58.00	05800	MRI	0.043599	815,004	35,533	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.182051	1,100,451	200,338	59.00
60.00	06000	LABORATORY	0.075656	8,969,106	678,567	60.00
65.00	06500	RESPIRATORY THERAPY	0.142107	3,944,862	560,593	65.00
66.00	06600	PHYSICAL THERAPY	0.434351	848,243	368,435	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.200805	479,876	96,362	67.00
68.00	06800	SPEECH PATHOLOGY	0.046572	122,267	5,694	68.00
69.00	06900	ELECTROCARDIOLOGY	0.061933	2,438,113	151,000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.157609	77,120	12,155	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.950635	956,442	909,227	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.248151	1,892,096	469,526	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.193624	6,827,827	1,322,031	73.00
74.00	07400	RENAL DIALYSIS	0.407901	754,766	307,870	74.00
76.00	03020	ANCILLARY	0.000000	0	0	76.00
76.01	03950	WOUND CARE	30.337853	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.503775	1,729	871	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.416086	3,107	1,293	90.00
90.01	09001	ACI	34.118910	0	0	90.01
91.00	09100	EMERGENCY	0.103242	5,274,636	544,564	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.408101	474,244	193,539	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		47,816,930	7,117,273	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)		47,816,930		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0304 Component CCN: 14-S304	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 3/20/2020 1:16 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		7,107,315		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.178618	0	0	50.00
51.00	05100 RECOVERY ROOM	0.221831	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.466359	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.015690	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.127034	124,618	15,831	54.00
56.00	05600 RADIOISOTOPE	0.147547	8,275	1,221	56.00
57.00	05700 CT SCAN	0.025944	267,048	6,928	57.00
58.00	05800 MRI	0.043599	19,416	847	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.182051	0	0	59.00
60.00	06000 LABORATORY	0.075656	917,845	69,440	60.00
65.00	06500 RESPIRATORY THERAPY	0.142107	108,343	15,396	65.00
66.00	06600 PHYSICAL THERAPY	0.434351	252,707	109,764	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.200805	84,171	16,902	67.00
68.00	06800 SPEECH PATHOLOGY	0.046572	14,937	696	68.00
69.00	06900 ELECTROCARDIOLOGY	0.061933	90,426	5,600	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.157609	2,540	400	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.950635	2,708	2,574	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.248151	1,080	268	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.193624	1,029,225	199,283	73.00
74.00	07400 RENAL DIALYSIS	0.407901	23,452	9,566	74.00
76.00	03020 ANCILLARY	0.000000	0	0	76.00
76.01	03950 WOUND CARE	30.337853	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0.503775	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.416086	0	0	90.00
90.01	09001 ACI	34.118910	0	0	90.01
91.00	09100 EMERGENCY	0.103242	456,537	47,134	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.408101	35,232	14,378	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		3,438,560	516,228	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		3,438,560		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0304	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 3/20/2020 1:16 pm
		Title XVIII	Hospital	PPS
				1.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	10,302,065		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3,369,026		1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0		1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0		1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount	0		2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0		2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	15,011		2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	0		2.04
3.00	Managed Care Simulated Payments	0		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	101.15		4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C) .		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.28	30.00
31.00	Percentage of Medicaid patient days (see instructions)		24.86	31.00
32.00	Sum of lines 30 and 31		29.14	32.00
33.00	Allowable disproportionate share percentage (see instructions)		13.26	33.00
34.00	Disproportionate share adjustment (see instructions)		453,197	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0304	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 3/20/2020 1:16 pm
		Title XVIII	Hospital	PPS
			Prior to 10/1	On/After 10/1
			1.00	2.00
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		8,272,872,447	8,350,599,096
35.01	Factor 3 (see instructions)		0.000132305	0.000099290
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		1,094,538	829,130
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		818,654	208,415
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,027,069	
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.0000000	
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	
47.00	Subtotal (see instructions)		15,166,368	
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)		15,166,368	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,177,371	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		16,343,739	59.00
60.00	Primary payer payments		11,045	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		16,332,694	61.00
62.00	Deductibles billed to program beneficiaries		1,499,992	62.00
63.00	Coinurance billed to program beneficiaries		15,345	63.00
64.00	Allowable bad debts (see instructions)		305,683	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		198,694	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		261,080	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		15,016,051	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		4,495	70.93
70.94	HRR adjustment amount (see instructions)		-91,007	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0304	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 3/20/2020 1:16 pm	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96	
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	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)		14,929,539	71.00	
71.01	Sequestration adjustment (see instructions)		298,591	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
72.00	Interim payments		14,616,463	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)		14,485	74.00	
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		530,987	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	

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0304

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
3/20/2020 1:16 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	10,302,065	0	10,064,279		10,064,279
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,369,026	0		3,603,732	3,603,732
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					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	15,011	0	0		0
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0		0	0
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0	0
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
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	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1326	0.1326	0.1326	0.1326	
11.00	Disproportionate share adjustment (see instructions)	34.00	453,197	0	333,733	119,464	453,197
11.01	Uncompensated care payments	36.00	1,027,069	0	843,093	275,884	1,118,977
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	15,166,368	0	11,167,288	3,999,080	15,166,368
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	15,166,368	0	11,167,288	3,999,080	15,166,368
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,177,371	0	-314,002	1,491,373	1,177,371

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0304

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
3/20/2020 1:16 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0
17.01	Net organ aquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	10,853,286	5,490,453	16,343,739
		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	1,106,873	0	-293,198	1,400,071	1,106,873
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	3,200	0	-2,978	6,178	3,200
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0608	0.0608	0.0608	0.0608	
25.00	Disproportionate share adjustment (see instructions)	11.00	67,298	0	-17,826	85,124	67,298
26.00	Total prospective capital payments (see instructions)	12.00	1,177,371	0	-314,002	1,491,373	1,177,371
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.000000	0.000000	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		N				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0304

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
3/20/2020 1:16 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	10,302,065	10,064,279		10,064,279	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,369,026		3,603,732	3,603,732	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	15,011	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1326	0.1326	0.1326		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	453,197	333,733	119,464	453,197	11.00
11.01	Uncompensated care payments	36.00	1,027,069	818,654	208,415	1,027,069	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	15,166,368	11,234,757	3,931,611	15,166,368	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	15,166,368	11,234,757	3,931,611	15,166,368	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,177,371	-314,002	1,491,373	1,177,371	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			10,920,755	5,422,984	16,343,739	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0304

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
3/20/2020 1:16 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,106,873	-293,198	1,400,071	1,106,873	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	3,200	-2,978	6,178	3,200	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0608	0.0608	0.0608		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	67,298	-17,826	85,124	67,298	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,177,371	-314,002	1,491,373	1,177,371	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	4,495	4,563	-68	4,495	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	-91,007	-58,373	-32,634	-91,007	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: 14-0304	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 3/20/2020 1:16 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		9,303	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		13,888,006	2.00
3.00	OPPS payments		11,443,876	3.00
4.00	Outlier payment (see instructions)		22,471	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		9,303	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		48,049	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)		48,049	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)		48,049	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		38,746	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)		9,303	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)		11,466,347	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)		2,043,540	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)		9,432,110	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)		9,432,110	30.00
31.00	Primary payer payments		7,913	31.00
32.00	Subtotal (line 30 minus line 31)		9,424,197	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)		314,360	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		204,334	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		209,261	36.00
37.00	Subtotal (see instructions)		9,628,531	37.00
38.00	MSP-LCC reconciliation amount from PS&R		412	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)		9,628,119	40.00
40.01	Sequestration adjustment (see instructions)		192,562	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		9,446,505	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-10,948	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: 14-0304 Component CCN: 14-S304	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 3/20/2020 1:16 pm
		Title XVIII	Subprovider - IPF	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		1,261	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		1,487	2.00
3.00	OPPS payments		2,662	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		1,261	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		10,774	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)		10,774	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)		10,774	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		9,513	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)		1,261	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)		2,662	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)		395	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)		3,528	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)		3,528	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		3,528	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)		3,528	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,528	40.00
40.01	Sequestration adjustment (see instructions)		71	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		572	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		2,885	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0304

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part I
Date/Time Prepared:
3/20/2020 1:16 pm

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		14,478,975		9,237,446	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		179,820		143,979	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	11/21/2019	65,080	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	11/21/2019	42,332		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)		-42,332		65,080	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)		14,616,463		9,446,505	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		14,485		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		10,948	6.02
7.00	Total Medicare program liability (see instructions)		14,630,948		9,435,557	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: 14-0304 Component CCN: 14-S304		Period: From 01/01/2019 To 12/31/2019		Worksheet E-1 Part I Date/Time Prepared: 3/20/2020 1:16 pm	
		Title XVIII		Subprovider - IPF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider						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		4,350,487		572		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)		4,350,487		572		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		10,311		2,885		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		4,360,798		3,457		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0304

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part II
Date/Time Prepared:
3/20/2020 1:16 pm

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0304 Component CCN: 14-S304	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part II Date/Time Prepared: 3/20/2020 1:16 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			4,679,060 1.00
2.00	Net IPF PPS Outlier Payments			1,235 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			16.542466 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			4,680,295 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			4,680,295 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			4,680,295 18.00
19.00	Deductibles			201,800 19.00
20.00	Subtotal (line 18 minus line 19)			4,478,495 20.00
21.00	Coinurance			39,215 21.00
22.00	Subtotal (line 20 minus line 21)			4,439,280 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			16,176 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			10,514 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			12,180 25.00
26.00	Subtotal (sum of lines 22 and 24)			4,449,794 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			4,449,794 31.00
31.01	Sequestration adjustment (see instructions)			88,996 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			4,350,487 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			10,311 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			1,235 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

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

Provider CCN: 14-0304

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

Worksheet G

Date/Time Prepared:
3/20/2020 1:16 pm

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	4,836,870	0	0	0	1.00
2.00 Temporary investments	204	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	81,276,605	0	0	0	4.00
5.00 Other receivable	0	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-57,801,077	0	0	0	6.00
7.00 Inventory	2,986,642	0	0	0	7.00
8.00 Prepaid expenses	279,282	0	0	0	8.00
9.00 Other current assets	0	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)	31,578,526	0	0	0	11.00
FIXED ASSETS					
12.00 Land	3,750,000	0	0	0	12.00
13.00 Land improvements	312,035	0	0	0	13.00
14.00 Accumulated depreciation	-156,589	0	0	0	14.00
15.00 Buildings	110,312,781	0	0	0	15.00
16.00 Accumulated depreciation	-43,058,435	0	0	0	16.00
17.00 Leasehold improvements	1,710,040	0	0	0	17.00
18.00 Accumulated depreciation	-1,268,139	0	0	0	18.00
19.00 Fixed equipment	23,136,181	0	0	0	19.00
20.00 Accumulated depreciation	-18,480,708	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	41,179,475	0	0	0	23.00
24.00 Accumulated depreciation	-36,798,464	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)	80,638,177	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	368,107	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	5,552,215	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	5,920,322	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	118,137,025	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	4,042,746	0	0	0	37.00
38.00 Salaries, wages, and fees payable	1,205,319	0	0	0	38.00
39.00 Payroll taxes payable	2,087,843	0	0	0	39.00
40.00 Notes and loans payable (short term)	0	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	0	0	0	0	43.00
44.00 Other current liabilities	23,554,633	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	30,890,541	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	69,689,176	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	1,195,992	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	70,885,168	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	101,775,709	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	16,361,316				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)	16,361,316	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	118,137,025	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0304

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

Worksheet G-1

Date/Time Prepared:
3/20/2020 1:16 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		8,922,572		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		9,648,232				2.00
3.00	Total (sum of line 1 and line 2)		18,570,804		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		18,570,804		0		11.00
12.00	UNRESTRICTED ASSETS	2,209,489		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)		2,209,489		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		16,361,315		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	UNRESTRICTED ASSETS		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: 14-0304

Period:
From 01/01/2019
To 12/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
3/20/2020 1:16 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	26,784,804		26,784,804	1.00
2.00	SUBPROVIDER - IPF	9,716,380		9,716,380	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	36,501,184		36,501,184	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,272,677		5,272,677	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)	5,272,677		5,272,677	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	41,773,861		41,773,861	17.00
18.00	Ancillary services	133,642,442	297,792,948	431,435,390	18.00
19.00	Outpatient services	16,623,043	65,199,752	81,822,795	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	PHARMACY	0	2,226,324	2,226,324	27.00
27.01	PHYSICIAN REVENUE	0	673,102	673,102	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	192,039,346	365,892,126	557,931,472	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		131,501,849		29.00
30.00	BAD DEBT	9,548,247			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)		9,548,247		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		141,050,096		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0304

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

Worksheet G-3

Date/Time Prepared:
3/20/2020 1:16 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	557,931,472	1.00
2.00	Less contractual allowances and discounts on patients' accounts	408,942,826	2.00
3.00	Net patient revenues (line 1 minus line 2)	148,988,646	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	141,050,096	4.00
5.00	Net income from service to patients (line 3 minus line 4)	7,938,550	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	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	0	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	EHR REVENUE; OTHER OPER; NON OPER	1,709,682	24.00
25.00	Total other income (sum of lines 6-24)	1,709,682	25.00
26.00	Total (line 5 plus line 25)	9,648,232	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)	9,648,232	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0304	Period: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III Date/Time Prepared: 3/20/2020 1:16 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,106,873	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		3,200	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)		53.22	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		4.28	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		24.86	8.00
9.00	Sum of lines 7 and 8		29.14	9.00
10.00	Allowable disproportionate share percentage (see instructions)		6.08	10.00
11.00	Disproportionate share adjustment (see instructions)		67,298	11.00
12.00	Total prospective capital payments (see instructions)		1,177,371	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