

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: 14-0307	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 6/11/2020 7:00 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 6/11/2020	Time: 7:00 am
	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 MEMORIAL HOSPITAL EAST (14-0307) 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)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	1,199,538	102,585	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	1,199,538	102,585	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: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part I
Date/Time Prepared:
6/11/2020 7:00 am

1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1404 CROSS STREET			PO Box:						1.00	
2.00	City: SHILOH			State: IL		Zip Code: 62269		County: ST. CLAIR		2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
								V	XVIII	XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		MEMORIAL HOSPITAL EAST		140307	41180	1	05/16/2016	N	P	O
4.00	Subprovider - IPF										
5.00	Subprovider - IRF										
6.00	Subprovider - (Other)										
7.00	Swing Beds - SNF										
8.00	Swing Beds - NF										
9.00	Hospital-Based SNF										
10.00	Hospital-Based NF										
11.00	Hospital-Based OLTC										
12.00	Hospital-Based HHA										
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		
21.00	Type of Control (see instructions)							2			
								1.00	2.00	3.00	
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N				
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N				
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N				
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		N		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N				
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
				1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			458	998	3	5	2,128	491		

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0307

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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	Y	40.00
						V	XVIII	XIX
						1.00	2.00	3.00
Prospective Payment System (PPS)-Capital								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals								
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
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.							
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
				1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)					N		60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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From 01/01/2019
To 12/31/2019Worksheet S-2
Part I
Date/Time Prepared:
6/11/2020 7:00 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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From 01/01/2019
To 12/31/2019Worksheet S-2
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
			1.00	2.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
			1.00	2.00	3.00		
70.00	Inpatient Psychiatric Facility PPS						
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
	Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	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	N	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	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.				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:	1,046,000	324,500		0118.01
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y		5.00	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		HB1804	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0307		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 6/11/2020 7:00 am	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: BJC HEALTHCARE	Contractor's Name: WPS		Contractor's Number: 05301				141.00	
142.00	Street: 4901 FOREST PARK PARKWAY	PO Box:						142.00	
143.00	City: ST. LOUIS	State: MO		Zip Code: 63108				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	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	161.00		
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							1.00	169.00
							Beginning	Ending	
							1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
							1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part II
Date/Time Prepared:
6/11/2020 7:00 am

		Y/N	Date	
		1.00	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	Date	V/I
		1.00	2.00	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	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
		Y/N	Legal Oper.	
		1.00	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.	N		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N	Date	Y/N
		1.00	2.00	3.00
		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)	Y	04/14/2020	Y
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)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part II
Date/Time Prepared:
6/11/2020 7:00 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	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.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				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.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MELINDA	HERNANDEZ		41.00
42.00	Enter the employer/company name of the cost report preparer.	BJC HEALTHCARE			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-362-0616	MELINDA.HERNANDEZ@BJC.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part II
Date/Time Prepared:
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		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.	REIMBURSEMENT MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
6/11/2020 7:00 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	88	32,120	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)		88	32,120	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	6	2,190	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)		94	34,310	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		94			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
6/11/2020 7:00 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4,637	541	12,649			1.00
2.00	HMO and other (see instructions)	2,262	2,052				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4,637	541	12,649			7.00
8.00	INTENSIVE CARE UNIT	464	91	990			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		1,232	3,074			13.00
14.00	Total (see instructions)	5,101	1,864	16,713	0.00	532.15	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	532.15	27.00
28.00	Observation Bed Days		0	1,047			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	167	443			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: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
6/11/2020 7:00 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,246	622	5,235	1.00
2.00 HMO and other (see instructions)			532	1,129		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,246	622	5,235	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part II
Date/Time Prepared:
6/11/2020 7:00 am

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	32,695,479	14,125	32,709,604	1,047,123.00	31.24
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)		151,631	0	151,631	10,046.00	15.09
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		599,488	0	599,488	7,189.00	83.39
12.00	Contract labor: Top level management and other management and administrative services		112,304	0	112,304	787.00	142.70
13.00	Contract labor: Physician-Part A - Administrative		391,703	0	391,703	2,426.00	161.46
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		4,612,947	0	4,612,947	104,121.00	44.30
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		7,473,048	0	7,473,048		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		34,658	0	34,658		
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)		678,096	0	678,096		
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	207,125	0	207,125	6,032.00	34.34
27.00	Administrative & General	5.00	3,995,688	1,000	3,996,688	134,036.00	29.82

6/11/2020 7:00 am

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part II
Date/Time Prepared:
6/11/2020 7:00 am

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		134,719	0	134,719	898.00	150.02	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	224,864	0	224,864	6,946.00	32.37	30.00
31.00	Laundry & Linen Service	8.00	0	79,621	79,621	4,850.00	16.42	31.00
32.00	Housekeeping	9.00	910,346	-79,621	830,725	58,898.00	14.10	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	457,026	0	457,026	27,965.00	16.34	34.00
35.00	Dietary under contract (see instructions)		286,553	0	286,553	7,280.00	39.36	35.00
36.00	Cafeteria	11.00	144,147	0	144,147	8,522.00	16.91	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,385,228	-51,347	1,333,881	31,132.00	42.85	38.00
39.00	Central Services and Supply	14.00	186,943	0	186,943	8,287.00	22.56	39.00
40.00	Pharmacy	15.00	1,520,201	0	1,520,201	36,066.00	42.15	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	186,514	0	186,514	6,791.00	27.46	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part III
Date/Time Prepared:
6/11/2020 7:00 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	33,116,751	14,125	33,130,876	1,055,301.00	31.39	1.00
2.00	Excluded area salaries (see instructions)	151,631	0	151,631	10,046.00	15.09	2.00
3.00	Subtotal salaries (line 1 minus line 2)	32,965,120	14,125	32,979,245	1,045,255.00	31.55	3.00
4.00	Subtotal other wages & related costs (see inst.)	5,716,442	0	5,716,442	114,523.00	49.92	4.00
5.00	Subtotal wage-related costs (see inst.)	8,151,144	0	8,151,144	0.00	24.72	5.00
6.00	Total (sum of lines 3 thru 5)	46,832,706	14,125	46,846,831	1,159,778.00	40.39	6.00
7.00	Total overhead cost (see instructions)	9,639,354	-50,347	9,589,007	337,703.00	28.39	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part IV
Date/Time Prepared:
6/11/2020 7:00 am

		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	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1,074,283	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)	2,991,772	8.02
8.03	Health Insurance (Purchased)	12,893	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	126,713	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	17,396	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)	364,579	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	33,085	14.00
15.00	'Workers' Compensation Insurance	369,099	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	2,333,024	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	25,452	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	124,753	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	7,473,049	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: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part V
Date/Time Prepared:
6/11/2020 7:00 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	1,184,252	7,473,048	1.00
2.00	Hospital	1,184,252	7,473,048	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0307	Period: From 01/01/2019 To 12/31/2019	Worksheet S-10 Date/Time Prepared: 6/11/2020 7:00 am	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.229790	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			6,467,001	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			41,751,279	6.00
7.00	Medicaid cost (line 1 times line 6)			9,594,026	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)			3,127,025	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)			3,127,025	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)	4,657,603	1,436,921	6,094,524	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,070,271	1,436,921	2,507,192	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,070,271	1,436,921	2,507,192	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)			5,651,066	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			280,005	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			430,777	27.01
28.00	Non-Medicare bad debt expense (see instructions)			5,220,289	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			1,350,342	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			3,857,534	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			6,984,559	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0307

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

Worksheet A

Date/Time Prepared:
6/11/2020 7:00 am

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	9,855,374	9,855,374	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT	0	0	2,048,430	2,048,430	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	5,042,085	5,042,085	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	207,125	743,939	951,064	7,251,115	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,995,688	17,801,429	21,797,117	-8,977,024	5.00
7.00	00700	OPERATION OF PLANT	224,864	3,547,959	3,772,823	-84,091	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	302,171	302,171	8.00
9.00	00900	HOUSEKEEPING	910,346	822,788	1,733,134	-628,953	9.00
10.00	01000	DIETARY	457,026	804,752	1,261,778	-402,474	10.00
11.00	01100	CAFETERIA	144,147	170,199	314,346	101,389	11.00
13.00	01300	NURSING ADMINISTRATION	1,385,228	517,867	1,903,095	-398,984	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	186,943	596,729	783,672	-190,292	14.00
15.00	01500	PHARMACY	1,520,201	2,294,433	3,814,634	-2,249,727	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	673,241	673,241	0	16.00
17.00	01700	SOCIAL SERVICE	186,514	69,546	256,060	-44,761	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,829,753	5,416,412	13,246,165	-3,809,168	30.00
31.00	03100	INTENSIVE CARE UNIT	1,196,101	490,138	1,686,239	-427,916	31.00
43.00	04300	NURSERY	768,738	226,495	995,233	861,442	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,978,756	4,310,399	7,289,155	-3,309,624	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,152,432	2,152,432	-131,655	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,928,858	3,192,069	6,120,927	-2,315,836	54.00
57.00	05700	CT SCAN	381,635	776,501	1,158,136	-767,986	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	132,716	510,351	643,067	-497,261	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	1,302,367	3,182,490	4,484,857	-602,030	60.00
65.00	06500	RESPIRATORY THERAPY	975,789	477,016	1,452,805	-329,399	65.00
66.00	06600	PHYSICAL THERAPY	992,175	383,513	1,375,688	-359,957	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,399,786	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,001,703	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,766,158	73.00
74.00	07400	RENAL DIALYSIS	0	147,667	147,667	0	74.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	3,838,878	1,560,629	5,399,507	-1,182,925	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	3,778,019	3,778,019	-3,579,428	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,543,848	54,647,013	87,190,861	1,340,162	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING 1	151,631	1,803,712	1,955,343	-1,340,162	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	32,695,479	56,450,725	89,146,204	0	200.00

6/11/2020 7:00 am

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0307

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

Worksheet A

Date/Time Prepared:
6/11/2020 7:00 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,123,710	11,979,084	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT	0	2,048,430	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	278,657	5,320,742	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	648,892	8,851,071	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	857,074	13,677,167	5.00
7.00	00700	OPERATION OF PLANT	-83,099	3,605,633	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	302,171	8.00
9.00	00900	HOUSEKEEPING	0	1,104,181	9.00
10.00	01000	DIETARY	0	859,304	10.00
11.00	01100	CAFETERIA	-366,104	49,631	11.00
13.00	01300	NURSING ADMINISTRATION	-9,452	1,494,659	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-86,888	506,492	14.00
15.00	01500	PHARMACY	-53	1,564,854	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-664,338	8,903	16.00
17.00	01700	SOCIAL SERVICE	0	211,299	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,329,738	7,107,259	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,258,323	31.00
43.00	04300	NURSERY	0	1,856,675	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-558,849	3,420,682	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-2,066,217	-45,440	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-58,639	3,746,452	54.00
57.00	05700	CT SCAN	-200	389,950	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-300	145,506	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-23,462	3,859,365	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,123,406	65.00
66.00	06600	PHYSICAL THERAPY	0	1,015,731	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,399,786	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,001,703	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,766,158	73.00
74.00	07400	RENAL DIALYSIS	0	147,667	74.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-211,263	4,005,319	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-198,591	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,748,860	85,782,163	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING 1	0	615,181	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,748,860	86,397,344	200.00

RECLASSIFICATIONS

Provider CCN: 14-0307

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

Worksheet A-6

Date/Time Prepared:
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Increases					
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
A - EQUIPMENT RENTAL					
1.00 CAP REL COSTS-MVBLE EQUIP	2.00	0	530,982		1.00
2.00	0.00	0	0		2.00
3.00	0.00	0	0		3.00
4.00	0.00	0	0		4.00
5.00	0.00	0	0		5.00
6.00	0.00	0	0		6.00
0		0	530,982		
B - MEDICAL SUPPLIES					
1.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,399,786		1.00
2.00 IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,001,703		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
0		0	4,401,489		
C - DRUGS SOLD					
1.00 DRUGS CHARGED TO PATIENTS	73.00	0	1,766,158		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
0		0	1,766,158		
D - NURSING FLOAT					
1.00 ADULTS & PEDIATRICS	30.00	51,347	17,980		1.00
0		51,347	17,980		
E - RECLASS CAFETERIA COST					
1.00 CAFETERIA	11.00	0	131,783		1.00
TOTALS		0	131,783		
F - DEPRECIATION					
1.00 CAP REL COSTS-BLDG & FIXT	1.00	0	6,884,550		1.00
2.00 CAP REL COSTS-BLDG & FIXT	1.01	0	2,041,142		2.00
3.00 CAP REL COSTS-MVBLE EQUIP	2.00	0	3,845,414		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
0		0	12,771,106		

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RECLASSIFICATIONS

Provider CCN: 14-0307

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

Worksheet A-6

Date/Time Prepared:
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	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	H - NURSERY/OB				
1.00	NURSERY _____	43.00	871,664	196,806	1.00
	0		871,664	196,806	
	I - INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	45,246	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.01	0	7,288	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	11,839	3.00
	0		0	64,373	
	J - INTEREST				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,925,578	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	653,850	2.00
	0		0	3,579,428	
	K - HOUSEKEEPING				
1.00	LAUNDRY & LINEN SERVICE	8.00	79,621	59,027	1.00
	0		79,621	59,027	
	M - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7,265,721	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
	0		0	7,265,721	
	O - RECRUITMENT RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	1,000	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	5,250	0	2.00
3.00	OPERATING ROOM	50.00	2,000	0	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	500	0	4.00
5.00	LABORATORY	60.00	500	0	5.00
6.00	EMERGENCY	91.00	4,875	0	6.00
	0		14,125	0	
	P - RECLASS LAUNDRY EXPENSE				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	163,523	1.00
	0		0	163,523	
500.00	Grand Total: Increases		1,016,757	30,948,376	500.00

RECLASSIFICATIONS

Provider CCN: 14-0307

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

Worksheet A-6

Date/Time Prepared:
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	Decreases					6/11/2020 7:00 am
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - EQUIPMENT RENTAL					
1.00	PHARMACY	15.00	0	331,676	14	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	47,463	0	2.00
3.00	INTENSIVE CARE UNIT	31.00	0	8,967	0	3.00
4.00	OPERATING ROOM	50.00	0	4,354	0	4.00
5.00	LABORATORY	60.00	0	118,061	0	5.00
6.00	RESPIRATORY THERAPY	65.00	0	20,461	0	6.00
	0		0	530,982		
	B - MEDICAL SUPPLIES					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	481	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	8,522	0	2.00
3.00	OPERATION OF PLANT	7.00	0	11,231	0	3.00
4.00	HOUSEKEEPING	9.00	0	67,825	0	4.00
5.00	DIETARY	10.00	0	6,490	0	5.00
6.00	NURSING ADMINISTRATION	13.00	0	7,108	0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	65,677	0	7.00
8.00	PHARMACY	15.00	0	171,800	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	754,377	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	133,262	0	10.00
11.00	NURSERY	43.00	0	32,803	0	11.00
12.00	OPERATING ROOM	50.00	0	2,204,045	0	12.00
13.00	ANESTHESIOLOGY	53.00	0	30,896	0	13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	379,060	0	14.00
15.00	CT SCAN	57.00	0	17,426	0	15.00
16.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	18,856	0	16.00
17.00	LABORATORY	60.00	0	98,493	0	17.00
18.00	RESPIRATORY THERAPY	65.00	0	4,461	0	18.00
19.00	PHYSICAL THERAPY	66.00	0	12,040	0	19.00
20.00	EMERGENCY	91.00	0	354,912	0	20.00
21.00	MEDICAL OFFICE BUILDING 1	194.01	0	21,724	0	21.00
	0		0	4,401,489		
	C - DRUGS SOLD					
1.00	PHARMACY	15.00	0	1,440,314	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	1,867	0	2.00
3.00	INTENSIVE CARE UNIT	31.00	0	143	0	3.00
4.00	OPERATING ROOM	50.00	0	1,437	0	4.00
5.00	ANESTHESIOLOGY	53.00	0	31,752	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	126,015	0	6.00
7.00	CT SCAN	57.00	0	140,583	0	7.00
8.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	21,731	0	8.00
9.00	LABORATORY	60.00	0	2,181	0	9.00
10.00	RESPIRATORY THERAPY	65.00	0	116	0	10.00
11.00	EMERGENCY	91.00	0	19	0	11.00
	0		0	1,766,158		
	D - NURSING FLOAT					
1.00	NURSING ADMINISTRATION	13.00	51,347	17,980	0	1.00
	0		51,347	17,980		
	E - RECLASS CAFETERIA COST					
1.00	DIETARY	10.00	0	131,783	0	1.00
	TOTALS		0	131,783		
	F - DEPRECIATION					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	8,003,901	9	1.00
2.00	OPERATION OF PLANT	7.00	0	17,023	9	2.00
3.00	HOUSEKEEPING	9.00	0	2,225	9	3.00
4.00	DIETARY	10.00	0	142,072	0	4.00
5.00	CAFETERIA	11.00	0	3,019	0	5.00
6.00	NURSING ADMINISTRATION	13.00	0	44,267	0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	60,329	0	7.00
8.00	PHARMACY	15.00	0	3,510	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	261,687	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	61,224	0	10.00
11.00	OPERATING ROOM	50.00	0	409,280	0	11.00
12.00	ANESTHESIOLOGY	53.00	0	69,007	0	12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,164,127	0	13.00
14.00	CT SCAN	57.00	0	511,357	0	14.00
15.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	434,877	0	15.00
16.00	LABORATORY	60.00	0	98,267	0	16.00
17.00	RESPIRATORY THERAPY	65.00	0	37,961	0	17.00
18.00	PHYSICAL THERAPY	66.00	0	120,660	0	18.00
19.00	EMERGENCY	91.00	0	7,875	0	19.00
20.00	MEDICAL OFFICE BUILDING 1	194.01	0	1,318,438	0	20.00

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RECLASSIFICATIONS

Provider CCN: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet A-6
Date/Time Prepared:
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	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	0		0	12,771,106			
	H - NURSERY/OB						
1.00	ADULTS & PEDIATRICS	30.00	871,664	196,806	0		1.00
	0		871,664	196,806			
	I - INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	64,373	12		1.00
2.00		0.00	0	0	12		2.00
3.00		0.00	0	0	12		3.00
	0		0	64,373			
	J - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	3,579,428	14		1.00
2.00		0.00	0	0	14		2.00
	0		0	3,579,428			
	K - HOUSEKEEPING						
1.00	HOUSEKEEPING	9.00	79,621	59,027	0		1.00
	0		79,621	59,027			
	M - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	901,228	0		1.00
2.00	OPERATION OF PLANT	7.00	0	55,837	0		2.00
3.00	HOUSEKEEPING	9.00	0	256,732	0		3.00
4.00	DIETARY	10.00	0	122,129	0		4.00
5.00	CAFETERIA	11.00	0	27,375	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	278,282	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	64,286	0		7.00
8.00	PHARMACY	15.00	0	302,427	0		8.00
9.00	SOCIAL SERVICE	17.00	0	44,761	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	1,749,881	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	0	224,320	0		11.00
12.00	NURSERY	43.00	0	174,225	0		12.00
13.00	OPERATING ROOM	50.00	0	692,508	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	647,134	0		14.00
15.00	CT SCAN	57.00	0	98,620	0		15.00
16.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	21,797	0		16.00
17.00	LABORATORY	60.00	0	285,528	0		17.00
18.00	RESPIRATORY THERAPY	65.00	0	266,400	0		18.00
19.00	PHYSICAL THERAPY	66.00	0	227,257	0		19.00
20.00	EMERGENCY	91.00	0	824,994	0		20.00
	0		0	7,265,721			
	O - RECRUITMENT RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	14,125	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	0		0	14,125			
	P - RECLASS LAUNDRY EXPENSE						
1.00	HOUSEKEEPING	9.00	0	163,523	0		1.00
	0		0	163,523			
500.00	Grand Total: Decreases		1,002,632	30,962,501			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0307

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	9,200,000	0	0	0	0	1.00
2.00	Land Improvements	7,159,577	1,737,258	0	1,737,258	0	2.00
3.00	Buildings and Fixtures	113,431,452	14,281,533	0	14,281,533	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	30,131,731	4,011,141	7,600	4,018,741	65,971	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	159,922,760	20,029,932	7,600	20,037,532	65,971	8.00
9.00	Reconciling Items	6,186,698	17,438,619	-20,029,931	-2,591,312	0	9.00
10.00	Total (line 8 minus line 9)	153,736,062	2,591,313	20,037,531	22,628,844	65,971	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	9,200,000	0				1.00
2.00	Land Improvements	8,896,835	0				2.00
3.00	Buildings and Fixtures	127,712,985	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	34,084,501	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	179,894,321	0				8.00
9.00	Reconciling Items	3,595,386	0				9.00
10.00	Total (line 8 minus line 9)	176,298,935	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part II
Date/Time Prepared:
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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
1.01	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.01
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
1.01	CAP REL COSTS-BLDG & FIXT	0	0				1.01
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: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part III
Date/Time Prepared:
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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	107,053,422	0	107,053,422	0.704063	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT	13,642,934	0	13,642,934	0.089726	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	31,354,529	0	31,354,529	0.206211	0	2.00
3.00	Total (sum of lines 1-2)	152,050,885	0	152,050,885	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	6,884,550	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT	0	0	0	2,041,142	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,845,414	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	12,771,106	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,857,841	45,246	0	3,191,447	11,979,084	1.00
1.01	CAP REL COSTS-BLDG & FIXT	0	7,288	0	0	2,048,430	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	119,624	11,839	0	1,343,865	5,320,742	2.00
3.00	Total (sum of lines 1-2)	1,977,465	64,373	0	4,535,312	19,348,256	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0307

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

Worksheet A-8

Date/Time Prepared:
6/11/2020 7:00 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-76,967	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.01	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-17,202	CAP REL COSTS-MVBLE EQUIP	2.00	11	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	-11,758	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,408,436			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	2,092,890			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-166,857	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
20.00	Vending machines	B	-14,178	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00

6/11/2020 7:00 am

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0307

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

Worksheet A-8

Date/Time Prepared:
6/11/2020 7:00 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME	B	-3,674	ADULTS & PEDIATRICS	30.00	0	33.00
33.01	MISC. INCOME	B	-385	RADIOLOGY-DIAGNOSTIC	54.00	0	33.01
33.02	MISC INCOME	B	-57,268	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	ALCOHOLIC BEVERAGES	A	-76	LABORATORY	60.00	0	33.03
33.04	COFFEE BAR	B	-185,069	CAFETERIA	11.00	0	33.04
33.05	ALCOHOLIC BEVERAGES	A	-2,290	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	CONTRIBUTION	A	-16,638	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.06
33.07	CONTRIBUTION	A	-55,351	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	CONTRIBUTION	A	-314	RADIOLOGY-DIAGNOSTIC	54.00	0	33.08
33.09	CONTRIBUTION	A	-5	LABORATORY	60.00	0	33.09
33.10	CONTRIBUTION	A	-608	EMERGENCY	91.00	0	33.10
33.11	ADVERTISING	A	-12,230	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	MEMBERSHIP DUES	A	-57,689	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	LOBBY EXPENSE	A	-25,917	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	ENTERTAINMENT EXPENSE	A	-3,950	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	AMORTIZED CAPITAL START UP	A	1,309,797	CAP REL COSTS-BLDG & FIXT	1.00	11	33.15
33.16	AMORITIZED START UP COSTS	A	96,285	ADMINISTRATIVE & GENERAL	5.00	11	33.16
33.18	AMORTIZATION LOSS ON FINANCING	A	625,011	CAP REL COSTS-BLDG & FIXT	1.00	11	33.18
33.19	AMORTIZATION LOSS ON FINANCING	A	136,826	CAP REL COSTS-MVBLE EQUIP	2.00	11	33.19
33.20	MALPRACTICE INSURANCE	A	-700,000	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21	RENT EXPENSE	A	-191,504	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	CONTRIBUTIONS	A	-53	PHARMACY	15.00	0	33.22
33.23	CONTRIBUTIONS	A	-666	ADULTS & PEDIATRICS	30.00	0	33.23
33.24	CONTRIBUTIONS	A	-84	OPERATING ROOM	50.00	0	33.24
33.25	CONTRIBUTIONS	A	-200	CT SCAN	57.00	0	33.25
33.26	CONTRIBUTIONS	A	-300	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	33.26
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,748,860				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0307

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

Worksheet A-8-1

Date/Time Prepared:
6/11/2020 7:00 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	1.00	CAP REL COSTS-BLDG & FIXT	OTHER EXP.	265,869	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	OTHER EXP.	159,033	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	SALARY	307,829	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	SALARY	1,227,509	0	3.01
3.02	14.00	CENTRAL SERVICES & SUPPLY	SALARY	247,964	0	3.02
3.03	7.00	OPERATION OF PLANT	SALARY	251,319	0	3.03
3.04	5.00	ADMINISTRATIVE & GENERAL	SALARY	17,114	0	3.04
3.05	5.00	ADMINISTRATIVE & GENERAL	SALARY	2,425,935	0	3.05
3.06	4.00	EMPLOYEE BENEFITS DEPARTMENT	OTHER EXP.	87,674	0	3.06
3.07	5.00	ADMINISTRATIVE & GENERAL	OTHER EXP.	1,492,789	0	3.07
3.08	14.00	CENTRAL SERVICES & SUPPLY	OTHER EXP.	26,820	0	3.08
3.09	5.00	ADMINISTRATIVE & GENERAL	OTHER EXP.	24,829	0	3.09
3.10	7.00	OPERATION OF PLANT	OTHER EXP.	1,483,449	0	3.10
3.11	5.00	ADMINISTRATIVE & GENERAL	OTHER EXP.	877,785	0	3.11
3.12	4.00	EMPLOYEE BENEFITS DEPARTMENT	OTHER EXP.	779,422	0	3.12
3.13	60.00	LABORATORY	REFERENCE LAB CHRISTIAN	50,377	35,665	3.13
3.14	5.00	ADMINISTRATIVE & GENERAL	BJC OVERHEAD ALLOCATION	0	103,492	3.14
3.15	4.00	EMPLOYEE BENEFITS DEPARTMENT	OTHER EXP.	0	503,031	3.15
3.16	5.00	ADMINISTRATIVE & GENERAL	OTHER EXP.	0	3,943,610	3.16
3.17	7.00	OPERATION OF PLANT	OTHER EXP.	0	1,817,867	3.17
3.18	14.00	CENTRAL SERVICES & SUPPLY	OTHER EXP.	0	361,672	3.18
3.19	16.00	MEDICAL RECORDS & LIBRARY	OTHER EXP.	0	664,338	3.19
3.20	113.00	INTEREST EXPENSE	OTHER EXP.	0	198,591	3.20
3.22	50.00	OPERATING ROOM	MIDWEST SURGICAL TECHNOLOGIE	6,082	9,030	3.22
4.00	5.00	ADMINISTRATIVE & GENERAL	TFC TELEPHONE EXPENSE	29,833	31,446	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			9,761,632	7,668,742	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	BJC HEALTHCARE	1.00	BJC HEALTHCARE	1.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-0307

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

Worksheet A-8-1

Date/Time Prepared:
6/11/2020 7:00 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	265,869	14		1.00
2.00	159,033	14		2.00
3.00	307,829	0		3.00
3.01	1,227,509	0		3.01
3.02	247,964	0		3.02
3.03	251,319	0		3.03
3.04	17,114	0		3.04
3.05	2,425,935	0		3.05
3.06	87,674	0		3.06
3.07	1,492,789	0		3.07
3.08	26,820	0		3.08
3.09	24,829	0		3.09
3.10	1,483,449	0		3.10
3.11	877,785	0		3.11
3.12	779,422	0		3.12
3.13	14,712	0		3.13
3.14	-103,492	0		3.14
3.15	-503,031	0		3.15
3.16	-3,943,610	0		3.16
3.17	-1,817,867	0		3.17
3.18	-361,672	0		3.18
3.19	-664,338	0		3.19
3.20	-198,591	0		3.20
3.22	-2,948	0		3.22
4.00	-1,613	0		4.00
5.00	2,092,890			5.00

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

	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			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: 14-0307

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

Worksheet A-8-2

Date/Time Prepared:
6/11/2020 7:00 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	11,527	0	11,527	179,000	60	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	292,027	47,909	244,118	179,000	1,784	2.00
3.00	13.00	NURSING ADMINISTRATION	23,738	0	23,738	179,000	166	3.00
4.00	30.00	ADULTS & PEDIATRICS	2,325,398	2,325,398	0	179,000	0	4.00
5.00	50.00	OPERATING ROOM	555,817	555,817	0	246,400	0	5.00
6.00	53.00	ANESTHESIOLOGY	2,066,217	2,066,217	0	239,400	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	112,320	0	112,320	271,900	416	7.00
8.00	60.00	LABORATORY	38,093	38,093	0	260,300	0	8.00
9.00	91.00	EMERGENCY	210,655	210,655	0	179,000	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			5,635,792	5,244,089	391,703		2,426	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	5,163	258	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	153,527	7,676	0	0	0	2.00
3.00	13.00	NURSING ADMINISTRATION	14,286	714	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	54,380	2,719	0	0	0	7.00
8.00	60.00	LABORATORY	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			227,356	11,367	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	5,163	6,364	6,364		1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	153,527	90,591	138,500		2.00
3.00	13.00	NURSING ADMINISTRATION	0	14,286	9,452	9,452		3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,325,398		4.00
5.00	50.00	OPERATING ROOM	0	0	0	555,817		5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	2,066,217		6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	54,380	57,940	57,940		7.00
8.00	60.00	LABORATORY	0	0	0	38,093		8.00
9.00	91.00	EMERGENCY	0	0	0	210,655		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	227,356	164,347	5,408,436		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
6/11/2020 7:00 am

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	BLDG & FIXT	MVBLE EQUIP		
		0	1.00	1.01	2.00	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	11,979,084	11,979,084			1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT	2,048,430	0	2,048,430		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	5,320,742		5,320,742		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,851,071	11,347	0	8,866,058	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,677,167	2,592,686	0	1,097,349	5.00
7.00	00700	OPERATION OF PLANT	3,605,633	1,027,775	109,322	61,127	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	302,171	0	0	21,644	8.00
9.00	00900	HOUSEKEEPING	1,104,181	352,004	0	225,823	9.00
10.00	01000	DIETARY	859,304	290,054	0	124,237	10.00
11.00	01100	CAFETERIA	49,631	100,163	0	39,185	11.00
13.00	01300	NURSING ADMINISTRATION	1,494,659	52,038	0	365,659	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	506,492	196,347	0	50,818	14.00
15.00	01500	PHARMACY	1,564,854	174,046	0	413,250	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,903	39,061	0	28,335	16.00
17.00	01700	SOCIAL SERVICE	211,299	6,847	0	50,702	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,107,259	3,150,622	0	1,894,313	30.00
31.00	03100	INTENSIVE CARE UNIT	1,258,323	314,378	0	326,030	31.00
43.00	04300	NURSERY	1,856,675	103,814	0	445,925	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,420,682	1,162,891	0	810,286	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-45,440	105,510	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,746,452	778,869	203,271	796,314	54.00
57.00	05700	CT SCAN	389,950	68,144	0	103,743	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	145,506	70,427	0	36,077	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	3,859,365	158,786	39,680	354,170	60.00
65.00	06500	RESPIRATORY THERAPY	1,123,406	81,773	0	265,258	65.00
66.00	06600	PHYSICAL THERAPY	1,015,731	42,452	215,801	269,712	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,399,786	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,001,703	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,766,158	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	147,667	8,151	0	2,615	74.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	4,005,319	562,828	0	1,044,882	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)	85,782,163	11,451,013	568,074	8,824,839	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	26,671	0	8,557	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	486,858	1,028,624	904,197	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07952	OTHER NONREIMBURSABLE COST CENTERS	0	14,542	451,732	324,426	194.00
194.01	07951	MEDICAL OFFICE BUILDING 1	615,181	0	0	41,219	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	86,397,344	11,979,084	2,048,430	8,866,058	202.00

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COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0307

Period:
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Cost Center Description			Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4A	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,199,011	18,199,011				5.00
7.00	00700	OPERATION OF PLANT	5,212,450	1,390,963	6,603,413			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	323,815	86,411	0	410,226		8.00
9.00	00900	HOUSEKEEPING	1,794,941	478,987	182,928	0	2,456,856	9.00
10.00	01000	DIETARY	1,366,653	364,697	150,735	0	57,680	10.00
11.00	01100	CAFETERIA	221,114	59,005	52,052	0	19,918	11.00
13.00	01300	NURSING ADMINISTRATION	1,929,051	514,775	27,043	0	10,348	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	816,651	217,927	102,037	0	39,045	14.00
15.00	01500	PHARMACY	2,207,989	589,211	90,447	0	34,611	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	88,831	23,705	20,299	0	7,768	16.00
17.00	01700	SOCIAL SERVICE	271,045	72,329	3,558	0	1,362	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,163,005	3,512,616	1,637,307	174,798	626,530	30.00
31.00	03100	INTENSIVE CARE UNIT	1,999,592	533,599	163,375	12,422	62,517	31.00
43.00	04300	NURSERY	2,439,721	651,049	53,950	19,572	20,644	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,766,948	1,538,933	604,328	53,587	231,251	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	93,921	25,063	54,831	0	20,982	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,921,406	1,580,151	642,248	62,991	245,762	54.00
57.00	05700	CT SCAN	583,700	155,763	35,413	0	13,551	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	274,605	73,279	36,599	0	14,005	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	4,491,565	1,198,592	128,877	0	49,316	60.00
65.00	06500	RESPIRATORY THERAPY	1,496,672	399,393	42,496	0	16,261	65.00
66.00	06600	PHYSICAL THERAPY	1,712,970	457,113	274,189	0	104,921	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,399,786	640,392	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,001,703	534,162	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,766,158	471,306	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	158,433	42,278	4,236	0	1,621	74.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	5,793,601	1,546,046	292,489	86,856	111,923	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	82,495,337	17,157,745	4,599,437	410,226	1,690,016	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	35,228	9,401	13,860	0	5,304	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,419,679	645,701	1,464,612	0	560,447	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07952	OTHER NONREIMBURSABLE COST CENTERS	790,700	211,001	525,504	0	201,089	194.00
194.01	07951	MEDICAL OFFICE BUILDING 1	656,400	175,163	0	0	0	194.01
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	86,397,344	18,199,011	6,603,413	410,226	2,456,856	202.00

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COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0307

Period:
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,939,765					10.00
11.00	01100	CAFETERIA	0	352,089				11.00
13.00	01300	NURSING ADMINISTRATION	0	13,622	2,494,839			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8,646	0	1,184,306		14.00
15.00	01500	PHARMACY	0	15,781	0	0	2,938,039	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,092	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	2,971	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,811,739	101,361	817,577	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	128,026	12,573	176,562	0	0	31.00
43.00	04300	NURSERY	0	18,534	502,764	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	33,594	431,669	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	39,635	68,705	0	0	54.00
57.00	05700	CT SCAN	0	5,192	15	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,461	23	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	20,869	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	13,989	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	11,998	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	638,265	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	546,041	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,938,039	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	45,771	497,524	0	0	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)	1,939,765	352,089	2,494,839	1,184,306	2,938,039	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING 1	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,939,765	352,089	2,494,839	1,184,306	2,938,039	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0307

Period:
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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
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	146,695					16.00
17.00	01700	SOCIAL SERVICE	0	351,265				17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,889	328,083	22,190,905	0	22,190,905	30.00
31.00	03100	INTENSIVE CARE UNIT	2,786	23,182	3,114,634	0	3,114,634	31.00
43.00	04300	NURSERY	2,841	0	3,709,075	0	3,709,075	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	15,382	0	8,675,692	0	8,675,692	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	4,177	0	198,974	0	198,974	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,887	0	8,583,785	0	8,583,785	54.00
57.00	05700	CT SCAN	17,497	0	811,131	0	811,131	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,440	0	403,412	0	403,412	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	22,128	0	5,911,347	0	5,911,347	60.00
65.00	06500	RESPIRATORY THERAPY	5,591	0	1,974,402	0	1,974,402	65.00
66.00	06600	PHYSICAL THERAPY	2,905	0	2,564,096	0	2,564,096	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,022	0	3,680,465	0	3,680,465	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,687	0	3,083,593	0	3,083,593	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,011	0	5,185,514	0	5,185,514	73.00
74.00	07400	RENAL DIALYSIS	206	0	206,774	0	206,774	74.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	15,246	0	8,389,456	0	8,389,456	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)	146,695	351,265	78,683,255	0	78,683,255	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	63,793	0	63,793	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	5,090,439	0	5,090,439	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	1,728,294	0	1,728,294	194.00
194.01	07951	MEDICAL OFFICE BUILDING 1	0	0	831,563	0	831,563	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	146,695	351,265	86,397,344	0	86,397,344	202.00

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ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0307

Period:
From 01/01/2019
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Cost Center Description			CAPITAL RELATED COSTS			Subtotal	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	BLDG & FIXT	MVBLE EQUIP	
			0	1.00	1.01	2.00	2A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	11,347	0	3,640	14,987
5.00	00500	ADMINISTRATIVE & GENERAL	0	2,592,686	0	831,809	3,424,495
7.00	00700	OPERATION OF PLANT	0	1,027,775	109,322	408,593	1,545,690
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0
9.00	00900	HOUSEKEEPING	0	352,004	0	112,933	464,937
10.00	01000	DIETARY	0	290,054	0	93,058	383,112
11.00	01100	CAFETERIA	0	100,163	0	32,135	132,298
13.00	01300	NURSING ADMINISTRATION	0	52,038	0	16,695	68,733
14.00	01400	CENTRAL SERVICES & SUPPLY	0	196,347	0	62,994	259,341
15.00	01500	PHARMACY	0	174,046	0	55,839	229,885
16.00	01600	MEDICAL RECORDS & LIBRARY	0	39,061	0	12,532	51,593
17.00	01700	SOCIAL SERVICE	0	6,847	0	2,197	9,044
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	3,150,622	0	1,010,811	4,161,433
31.00	03100	INTENSIVE CARE UNIT	0	314,378	0	100,861	415,239
43.00	04300	NURSERY	0	103,814	0	33,307	137,121
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,162,891	0	373,089	1,535,980
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0	105,510	0	33,851	139,361
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	778,869	203,271	396,500	1,378,640
57.00	05700	CT SCAN	0	68,144	0	21,863	90,007
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	70,427	0	22,595	93,022
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	0	158,786	39,680	79,564	278,030
65.00	06500	RESPIRATORY THERAPY	0	81,773	0	26,235	108,008
66.00	06600	PHYSICAL THERAPY	0	42,452	215,801	169,274	427,527
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	8,151	0	2,615	10,766
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	562,828	0	180,572	743,400
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	11,451,013	568,074	4,083,562	16,102,649
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	26,671	0	8,557	35,228
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	486,858	1,028,624	904,197	2,419,679
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07952	OTHER NONREIMBURSABLE COST CENTERS	0	14,542	451,732	324,426	790,700
194.01	07951	MEDICAL OFFICE BUILDING 1	0	0	0	0	0
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers					0
202.00		TOTAL (sum lines 118 through 201)	0	11,979,084	2,048,430	5,320,742	19,348,256

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ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
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Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4.00	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	14,987					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,857	3,426,352				5.00
7.00	00700	OPERATION OF PLANT	103	261,879	1,807,672			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	37	16,269	0	16,306		8.00
9.00	00900	HOUSEKEEPING	382	90,180	50,076	0	605,575	9.00
10.00	01000	DIETARY	210	68,662	41,263	0	14,217	10.00
11.00	01100	CAFETERIA	66	11,109	14,249	0	4,910	11.00
13.00	01300	NURSING ADMINISTRATION	619	96,917	7,403	0	2,551	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	86	41,029	27,933	0	9,624	14.00
15.00	01500	PHARMACY	699	110,932	24,760	0	8,531	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	48	4,463	5,557	0	1,915	16.00
17.00	01700	SOCIAL SERVICE	86	13,618	974	0	336	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,189	661,320	448,208	6,948	154,428	30.00
31.00	03100	INTENSIVE CARE UNIT	552	100,462	44,724	494	15,409	31.00
43.00	04300	NURSERY	755	122,574	14,769	778	5,089	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,371	289,737	165,434	2,130	57,000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	4,719	15,010	0	5,172	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,348	297,497	175,814	2,504	60,576	54.00
57.00	05700	CT SCAN	176	29,326	9,694	0	3,340	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	61	13,796	10,019	0	3,452	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	599	225,661	35,280	0	12,156	60.00
65.00	06500	RESPIRATORY THERAPY	449	75,194	11,633	0	4,008	65.00
66.00	06600	PHYSICAL THERAPY	456	86,061	75,059	0	25,861	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	120,568	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	100,568	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	88,734	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	7,960	1,160	0	400	74.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	1,768	291,076	80,068	3,452	27,587	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)	14,917	3,230,311	1,259,087	16,306	416,562	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,770	3,794	0	1,307	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	121,567	400,935	0	138,141	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07952	OTHER NONREIMBURSABLE COST CENTERS	0	39,726	143,856	0	49,565	194.00
194.01	07951	MEDICAL OFFICE BUILDING 1	70	32,978	0	0	0	194.01
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	14,987	3,426,352	1,807,672	16,306	605,575	202.00

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ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0307

Period:
From 01/01/2019
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	507,464					10.00
11.00	01100	CAFETERIA	0	162,632				11.00
13.00	01300	NURSING ADMINISTRATION	0	6,292	182,515			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,994	0	342,007		14.00
15.00	01500	PHARMACY	0	7,289	0	0	382,096	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,814	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,373	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	473,971	46,819	59,811	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	33,493	5,808	12,917	0	0	31.00
43.00	04300	NURSERY	0	8,561	36,781	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	15,517	31,580	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,307	5,026	0	0	54.00
57.00	05700	CT SCAN	0	2,398	1	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	675	2	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	9,639	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	6,462	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	5,542	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	184,321	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	157,686	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	382,096	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	21,142	36,397	0	0	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)	507,464	162,632	182,515	342,007	382,096	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING 1	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	507,464	162,632	182,515	342,007	382,096	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet B
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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
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	66,390					16.00
17.00	01700	SOCIAL SERVICE	0	25,431				17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,108	23,753	6,047,988	0	6,047,988	30.00
31.00	03100	INTENSIVE CARE UNIT	1,263	1,678	632,039	0	632,039	31.00
43.00	04300	NURSERY	1,288	0	327,716	0	327,716	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,972	0	2,105,721	0	2,105,721	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,893	0	166,155	0	166,155	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,274	0	1,949,986	0	1,949,986	54.00
57.00	05700	CT SCAN	7,931	0	142,873	0	142,873	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,559	0	122,586	0	122,586	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	10,030	0	571,395	0	571,395	60.00
65.00	06500	RESPIRATORY THERAPY	2,534	0	208,288	0	208,288	65.00
66.00	06600	PHYSICAL THERAPY	1,317	0	621,823	0	621,823	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	916	0	305,805	0	305,805	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	764	0	259,018	0	259,018	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,537	0	475,367	0	475,367	73.00
74.00	07400	RENAL DIALYSIS	93	0	20,379	0	20,379	74.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	6,911	0	1,211,801	0	1,211,801	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)	66,390	25,431	15,168,940	0	15,168,940	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	42,099	0	42,099	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	3,080,322	0	3,080,322	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	1,023,847	0	1,023,847	194.00
194.01	07951	MEDICAL OFFICE BUILDING 1	0	0	33,048	0	33,048	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	66,390	25,431	19,348,256	0	19,348,256	202.00

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0307

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			BLDG & FIXT (SQUARE FEET)	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)			
			1.00	1.01	2.00			
	GENERAL SERVICE COST CENTERS						5A	
1.00	00100	CAP REL COSTS-BLDG & FIXT	183,700					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT	0	70,622				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			254,322			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	174	0	174	32,615,141		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	39,759	0	39,759	4,036,762	-18,199,011	5.00
7.00	00700	OPERATION OF PLANT	15,761	3,769	19,530	224,864	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	79,621	0	8.00
9.00	00900	HOUSEKEEPING	5,398	0	5,398	830,725	0	9.00
10.00	01000	DIETARY	4,448	0	4,448	457,026	0	10.00
11.00	01100	CAFETERIA	1,536	0	1,536	144,147	0	11.00
13.00	01300	NURSING ADMINISTRATION	798	0	798	1,345,131	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,011	0	3,011	186,943	0	14.00
15.00	01500	PHARMACY	2,669	0	2,669	1,520,201	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	599	0	599	104,233	0	16.00
17.00	01700	SOCIAL SERVICE	105	0	105	186,514	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	48,315	0	48,315	6,968,544	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,821	0	4,821	1,199,348	0	31.00
43.00	04300	NURSERY	1,592	0	1,592	1,640,402	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	17,833	0	17,833	2,980,756	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,618	0	1,618	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,944	7,008	18,952	2,929,358	0	54.00
57.00	05700	CT SCAN	1,045	0	1,045	381,635	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,080	0	1,080	132,716	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,435	1,368	3,803	1,302,867	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,254	0	1,254	975,789	0	65.00
66.00	06600	PHYSICAL THERAPY	651	7,440	8,091	992,175	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	125	0	125	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	8,631	0	8,631	3,843,753	0	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)	175,602	19,585	195,187	32,463,510	-18,199,011	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	409	0	409	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,466	35,463	43,219	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07952	OTHER NONREIMBURSABLE COST CENTERS	223	15,574	15,507	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING 1	0	0	0	151,631	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	11,979,084	2,048,430	5,320,742	8,866,058		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	65.210038	29.005551	20.921281	0.271839		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				14,987		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000460		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

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0307

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	68,198,333				5.00
7.00	00700	OPERATION OF PLANT	5,212,450	194,859			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	323,815	0	376,125		8.00
9.00	00900	HOUSEKEEPING	1,794,941	5,398	0	189,461	9.00
10.00	01000	DIETARY	1,366,653	4,448	0	4,448	10.00
11.00	01100	CAFETERIA	221,114	1,536	0	1,536	11.00
13.00	01300	NURSING ADMINISTRATION	1,929,051	798	0	798	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	816,651	3,011	0	3,011	14.00
15.00	01500	PHARMACY	2,207,989	2,669	0	2,669	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	88,831	599	0	599	16.00
17.00	01700	SOCIAL SERVICE	271,045	105	0	105	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	13,163,005	48,315	160,268	48,315	30.00
31.00	03100	INTENSIVE CARE UNIT	1,999,592	4,821	11,389	4,821	31.00
43.00	04300	NURSERY	2,439,721	1,592	17,945	1,592	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,766,948	17,833	49,132	17,833	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	93,921	1,618	0	1,618	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,921,406	18,952	57,755	18,952	54.00
57.00	05700	CT SCAN	583,700	1,045	0	1,045	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	274,605	1,080	0	1,080	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	4,491,565	3,803	0	3,803	60.00
65.00	06500	RESPIRATORY THERAPY	1,496,672	1,254	0	1,254	65.00
66.00	06600	PHYSICAL THERAPY	1,712,970	8,091	0	8,091	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,399,786	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,001,703	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,766,158	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	158,433	125	0	125	74.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	5,793,601	8,631	79,636	8,631	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)	64,296,326	135,724	376,125	130,326	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	35,228	409	0	409	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,419,679	43,219	0	43,219	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07952	OTHER NONREIMBURSABLE COST CENTERS	790,700	15,507	0	15,507	194.00
194.01	07951	MEDICAL OFFICE BUILDING 1	656,400	0	0	0	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	18,199,011	6,603,413	410,226	2,456,856	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.266854	33.888160	1.090664	12.967608	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	3,426,352	1,807,672	16,306	605,575	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.050241	9.276821	0.043353	3.196304	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

6/11/2020 7:00 am

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0307

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

Worksheet B-1

Date/Time Prepared:
6/11/2020 7:00 am

Cost Center Description			CAFETERIA (EMPLOYEE HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	804,667					11.00
13.00	01300	NURSING ADMINISTRATION	31,131	331,860				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,759	0	4,341,489			14.00
15.00	01500	PHARMACY	36,066	0	0	1,722,323		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,922	0	0	0	342,414,037	16.00
17.00	01700	SOCIAL SERVICE	6,791	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	231,655	108,753	0	0	41,795,615	30.00
31.00	03100	INTENSIVE CARE UNIT	28,735	23,486	0	0	6,508,260	31.00
43.00	04300	NURSERY	42,357	66,877	0	0	6,638,856	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	76,775	57,420	0	0	35,939,308	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	9,759,594	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	90,581	9,139	0	0	53,146,541	54.00
57.00	05700	CT SCAN	11,865	2	0	0	40,881,816	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,339	3	0	0	8,037,625	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	47,694	0	0	0	51,700,333	60.00
65.00	06500	RESPIRATORY THERAPY	31,971	0	0	0	13,062,777	65.00
66.00	06600	PHYSICAL THERAPY	27,420	0	0	0	6,786,818	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,339,786	0	4,724,088	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,001,703	0	3,940,444	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,722,323	23,389,026	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	481,236	74.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	104,606	66,180	0	0	35,621,700	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)	804,667	331,860	4,341,489	1,722,323	342,414,037	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING 1	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	352,089	2,494,839	1,184,306	2,938,039	146,695	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.437559	7.517745	0.272788	1.705858	0.000428	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	162,632	182,515	342,007	382,096	66,390	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.202111	0.549976	0.078776	0.221849	0.000194	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

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0307

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

Worksheet B-1

Date/Time Prepared:
6/11/2020 7:00 am

Cost Center Description			SOCIAL SERVICE	
			(PATIENT DAYS)	
			17.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
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	15,001	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	14,011	30.00
31.00	03100	INTENSIVE CARE UNIT	990	31.00
43.00	04300	NURSERY	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
74.00	07400	RENAL DIALYSIS	0	74.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	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)	15,001	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
193.00	19300	NONPAID WORKERS	0	193.00
194.00	07952	OTHER NONREIMBURSABLE COST CENTERS	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING 1	0	194.01
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	351,265	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.416106	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	25,431	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.695287	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

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COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
6/11/2020 7:00 am

				Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	22,190,905		22,190,905	0	22,190,905	30.00	
31.00	03100	INTENSIVE CARE UNIT	3,114,634		3,114,634	0	3,114,634	31.00	
43.00	04300	NURSERY	3,709,075		3,709,075	0	3,709,075	43.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	8,675,692		8,675,692	0	8,675,692	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	198,974		198,974	0	198,974	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,583,785		8,583,785	57,940	8,641,725	54.00	
57.00	05700	CT SCAN	811,131		811,131	0	811,131	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	403,412		403,412	0	403,412	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00	
60.00	06000	LABORATORY	5,911,347		5,911,347	0	5,911,347	60.00	
65.00	06500	RESPIRATORY THERAPY	1,974,402	0	1,974,402	0	1,974,402	65.00	
66.00	06600	PHYSICAL THERAPY	2,564,096	0	2,564,096	0	2,564,096	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	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,680,465		3,680,465	0	3,680,465	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,083,593		3,083,593	0	3,083,593	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	5,185,514		5,185,514	0	5,185,514	73.00	
74.00	07400	RENAL DIALYSIS	206,774		206,774	0	206,774	74.00	
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	8,389,456		8,389,456	0	8,389,456	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,696,402		1,696,402		1,696,402	92.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	80,379,657	0	80,379,657	57,940	80,437,597	200.00	
201.00		Less Observation Beds	1,696,402		1,696,402		1,696,402	201.00	
202.00		Total (see instructions)	78,683,255	0	78,683,255	57,940	78,741,195	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
6/11/2020 7:00 am

			Title XVIII		Hospital	PPS		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	39,549,649		39,549,649			30.00
31.00	03100	INTENSIVE CARE UNIT	6,508,260		6,508,260			31.00
43.00	04300	NURSERY	6,638,856		6,638,856			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,479,118	30,460,190	35,939,308	0.241398	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	4,644,497	5,115,097	9,759,594	0.020388	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,036,227	41,110,314	53,146,541	0.161512	0.000000	54.00
57.00	05700	CT SCAN	6,453,494	34,428,322	40,881,816	0.019841	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	748,369	7,289,256	8,037,625	0.050190	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	18,491,213	33,209,120	51,700,333	0.114339	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	10,598,495	2,464,282	13,062,777	0.151147	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,550,679	5,236,139	6,786,818	0.377805	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	867,469	3,856,619	4,724,088	0.779085	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,076,759	2,863,685	3,940,444	0.782550	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,540,398	5,848,628	23,389,026	0.221707	0.000000	73.00
74.00	07400	RENAL DIALYSIS	460,231	21,005	481,236	0.429673	0.000000	74.00
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	5,056,214	30,565,486	35,621,700	0.235515	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	206,355	2,039,611	2,245,966	0.755311	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	137,906,283	204,507,754	342,414,037			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	137,906,283	204,507,754	342,414,037			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
6/11/2020 7:00 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.241398			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300 ANESTHESIOLOGY	0.020388			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.162602			54.00
57.00	05700 CT SCAN	0.019841			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.050190			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000 LABORATORY	0.114339			60.00
65.00	06500 RESPIRATORY THERAPY	0.151147			65.00
66.00	06600 PHYSICAL THERAPY	0.377805			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
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.779085			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.782550			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.221707			73.00
74.00	07400 RENAL DIALYSIS	0.429673			74.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.235515			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.755311			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: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
6/11/2020 7:00 am

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	22,190,905		22,190,905	0	22,190,905	30.00
31.00	03100	INTENSIVE CARE UNIT	3,114,634		3,114,634	0	3,114,634	31.00
43.00	04300	NURSERY	3,709,075		3,709,075	0	3,709,075	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,675,692		8,675,692	0	8,675,692	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	198,974		198,974	0	198,974	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,583,785		8,583,785	57,940	8,641,725	54.00
57.00	05700	CT SCAN	811,131		811,131	0	811,131	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	403,412		403,412	0	403,412	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	5,911,347		5,911,347	0	5,911,347	60.00
65.00	06500	RESPIRATORY THERAPY	1,974,402	0	1,974,402	0	1,974,402	65.00
66.00	06600	PHYSICAL THERAPY	2,564,096	0	2,564,096	0	2,564,096	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	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,680,465		3,680,465	0	3,680,465	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,083,593		3,083,593	0	3,083,593	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,185,514		5,185,514	0	5,185,514	73.00
74.00	07400	RENAL DIALYSIS	206,774		206,774	0	206,774	74.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	8,389,456		8,389,456	0	8,389,456	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,696,402		1,696,402		1,696,402	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	80,379,657	0	80,379,657	57,940	80,437,597	200.00
201.00		Less Observation Beds	1,696,402		1,696,402		1,696,402	201.00
202.00		Total (see instructions)	78,683,255	0	78,683,255	57,940	78,741,195	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
6/11/2020 7:00 am

			Title XIX		Hospital	Cost		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	39,549,649		39,549,649			30.00
31.00	03100	INTENSIVE CARE UNIT	6,508,260		6,508,260			31.00
43.00	04300	NURSERY	6,638,856		6,638,856			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,479,118	30,460,190	35,939,308	0.241398	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	4,644,497	5,115,097	9,759,594	0.020388	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,036,227	41,110,314	53,146,541	0.161512	0.000000	54.00
57.00	05700	CT SCAN	6,453,494	34,428,322	40,881,816	0.019841	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	748,369	7,289,256	8,037,625	0.050190	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	18,491,213	33,209,120	51,700,333	0.114339	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	10,598,495	2,464,282	13,062,777	0.151147	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,550,679	5,236,139	6,786,818	0.377805	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	867,469	3,856,619	4,724,088	0.779085	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,076,759	2,863,685	3,940,444	0.782550	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,540,398	5,848,628	23,389,026	0.221707	0.000000	73.00
74.00	07400	RENAL DIALYSIS	460,231	21,005	481,236	0.429673	0.000000	74.00
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	5,056,214	30,565,486	35,621,700	0.235515	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	206,355	2,039,611	2,245,966	0.755311	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	137,906,283	204,507,754	342,414,037			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	137,906,283	204,507,754	342,414,037			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
6/11/2020 7:00 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
OUTPATIENT SERVICE COST CENTERS						
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: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part I
Date/Time Prepared:
6/11/2020 7:00 am

			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	6,047,988	0	6,047,988	13,696	441.59	30.00
31.00	INTENSIVE CARE UNIT	632,039		632,039	990	638.42	31.00
43.00	NURSERY	327,716		327,716	3,074	106.61	43.00
200.00	Total (lines 30 through 199)	7,007,743		7,007,743	17,760		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	4,637	2,047,653				30.00
31.00	INTENSIVE CARE UNIT	464	296,227				31.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	5,101	2,343,880				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part II
Date/Time Prepared:
6/11/2020 7:00 am

Cost Center Description			Title XVIII		Hospital	PPS	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,105,721	35,939,308	0.058591	1,679,363	98,396
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0
53.00	05300	ANESTHESIOLOGY	166,155	9,759,594	0.017025	388,561	6,615
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,949,986	53,146,541	0.036691	6,664,768	244,537
57.00	05700	CT SCAN	142,873	40,881,816	0.003495	3,274,454	11,444
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	122,586	8,037,625	0.015252	360,333	5,496
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0
60.00	06000	LABORATORY	571,395	51,700,333	0.011052	7,565,655	83,616
65.00	06500	RESPIRATORY THERAPY	208,288	13,062,777	0.015945	5,332,813	85,032
66.00	06600	PHYSICAL THERAPY	621,823	6,786,818	0.091622	815,110	74,682
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	305,805	4,724,088	0.064733	276,001	17,866
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	259,018	3,940,444	0.065733	108,087	7,105
73.00	07300	DRUGS CHARGED TO PATIENTS	475,367	23,389,026	0.020324	6,141,534	124,821
74.00	07400	RENAL DIALYSIS	20,379	481,236	0.042347	333,718	14,132
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	1,211,801	35,621,700	0.034019	2,253,836	76,673
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	462,344	2,245,966	0.205855	142,803	29,397
200.00		Total (lines 50 through 199)	8,623,541	289,717,272		35,337,036	879,812

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0307		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part III Date/Time Prepared: 6/11/2020 7:00 am		
					Title XVIII		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00	
43.00	04300	NURSERY		0	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	13,696	0.00	4,637		30.00	
31.00	03100	INTENSIVE CARE UNIT			0	990	0.00	464		31.00	
43.00	04300	NURSERY			0	3,074	0.00	0		43.00	
200.00		Total (lines 30 through 199)			0	17,760		5,101		200.00	
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0						30.00	
31.00	03100	INTENSIVE CARE UNIT		0						31.00	
43.00	04300	NURSERY		0						43.00	
200.00		Total (lines 30 through 199)		0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0307		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 6/11/2020 7:00 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		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
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		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: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
6/11/2020 7:00 am

				Title XVIII		Hospital	PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	35,939,308	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	9,759,594	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	53,146,541	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	40,881,816	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	8,037,625	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	51,700,333	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,062,777	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,786,818	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,724,088	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,940,444	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	23,389,026	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	481,236	0.000000	74.00
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	35,621,700	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,245,966	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	289,717,272		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
6/11/2020 7:00 am

Cost Center Description			Title XVIII		Hospital		PPS
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
			9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	1,679,363	0	5,822,732	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0.000000	388,561	0	978,735	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	6,664,768	0	9,624,929	0
57.00	05700	CT SCAN	0.000000	3,274,454	0	8,342,558	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	360,333	0	1,803,404	0
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00	06000	LABORATORY	0.000000	7,565,655	0	3,912,967	0
65.00	06500	RESPIRATORY THERAPY	0.000000	5,332,813	0	714,053	0
66.00	06600	PHYSICAL THERAPY	0.000000	815,110	0	25,159	0
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	276,001	0	560,872	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	108,087	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	6,141,534	0	2,111,685	0
74.00	07400	RENAL DIALYSIS	0.000000	333,718	0	9,222	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.000000	2,253,836	0	4,289,252	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	142,803	0	470,818	0
200.00		Total (lines 50 through 199)		35,337,036	0	38,666,386	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
6/11/2020 7:00 am

				Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.241398	5,822,732	0	1,024	1,405,596	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.020388	978,735	0	4,608	19,954	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161512	9,624,929	0	0	1,554,542	54.00	
57.00	05700	CT SCAN	0.019841	8,342,558	0	7,168	165,525	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.050190	1,803,404	0	2,048	90,513	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00	
60.00	06000	LABORATORY	0.114339	3,912,967	0	0	447,405	60.00	
65.00	06500	RESPIRATORY THERAPY	0.151147	714,053	0	0	107,927	65.00	
66.00	06600	PHYSICAL THERAPY	0.377805	25,159	0	0	9,505	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	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.779085	560,872	0	0	436,967	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.782550	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.221707	2,111,685	0	36,353	468,175	73.00	
74.00	07400	RENAL DIALYSIS	0.429673	9,222	0	0	3,962	74.00	
	OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.235515	4,289,252	0	0	1,010,183	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.755311	470,818	0	0	355,614	92.00	
200.00		Subtotal (see instructions)		38,666,386	0	51,201	6,075,868	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		38,666,386	0	51,201	6,075,868	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
6/11/2020 7:00 am

				Title XVIII	Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	247		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	94		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	142		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	103		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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,060		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	8,646		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	8,646		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
6/11/2020 7:00 am

			Title XIX		Hospital		Cost		
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	0.241398	0	438,588	0	0	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.020388	0	76,088	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161512	0	499,599	0	0	54.00	
57.00	05700	CT SCAN	0.019841	0	509,678	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.050190	0	38,074	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00	
60.00	06000	LABORATORY	0.114339	0	694,058	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0.151147	0	37,889	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.377805	0	25,465	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	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.779085	0	63,484	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.782550	0	15,002	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.221707	0	110,032	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0.429673	0	0	0	0	74.00	
	OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.235515	0	1,094,497	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.755311	0	0	0	0	92.00	
200.00		Subtotal (see instructions)		0	3,602,454	0	0	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		0	3,602,454	0	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
6/11/2020 7:00 am

				Title XIX	Hospital	Cost
	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	105,874	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	1,551	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	80,691	0		54.00
57.00	05700	CT SCAN	10,113	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,911	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	79,358	0		60.00
65.00	06500	RESPIRATORY THERAPY	5,727	0		65.00
66.00	06600	PHYSICAL THERAPY	9,621	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	49,459	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,740	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,395	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	257,770	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	638,210	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	638,210	0		202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0307

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

Worksheet D-1

Date/Time Prepared:
6/11/2020 7:00 am

Title XVIII		Hospital	PPS
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	13,696	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13,696	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)	12,649	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)	4,637	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)	22,190,905	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)	22,190,905	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)	22,190,905	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY			
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,620.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	7,513,099	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)	7,513,099	41.00

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COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0307

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

Worksheet D-1

Date/Time Prepared:
6/11/2020 7:00 am

Cost Center Description		Title XVIII		Hospital		PPS
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,114,634	990	3,146.09	464	1,459,786
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)					6,002,411
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					14,975,296
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					2,343,880
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					879,812
52.00	Total Program excludable cost (sum of lines 50 and 51)					3,223,692
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					11,751,604
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					1,047
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,620.25
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,696,402

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COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0307

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

Worksheet D-1

Date/Time Prepared:
6/11/2020 7:00 am

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	6,047,988	22,190,905	0.272544	1,696,402	462,344	90.00
91.00 Nursing School cost	0	22,190,905	0.000000	1,696,402	0	91.00
92.00 Allied health cost	0	22,190,905	0.000000	1,696,402	0	92.00
93.00 All other Medical Education	0	22,190,905	0.000000	1,696,402	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0307

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

Worksheet D-1

Date/Time Prepared:
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Title XIX		Hospital	Cost
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	13,696	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13,696	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)	12,649	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)	541	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)	3,074	15.00
16.00	Nursery days (title V or XIX only)	1,232	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)	22,190,905	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)	22,190,905	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)	22,190,905	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY			
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,620.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	876,555	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)	876,555	41.00

6/11/2020 7:00 am

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0307

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

Worksheet D-1

Date/Time Prepared:
6/11/2020 7:00 am

		Title XIX		Hospital		Cost	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	3,709,075	3,074	1,206.60	1,232	1,486,531	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	3,114,634	990	3,146.09	91	286,294	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)					286,605	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,935,985	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)					1,047	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,620.25	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,696,402	89.00

6/11/2020 7:00 am

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0307

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

Worksheet D-1

Date/Time Prepared:
6/11/2020 7:00 am

		Title XIX		Hospital	Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	6,047,988	22,190,905	0.272544	1,696,402	462,344
91.00	Nursing School cost	0	22,190,905	0.000000	1,696,402	0
92.00	Allied health cost	0	22,190,905	0.000000	1,696,402	0
93.00	All other Medical Education	0	22,190,905	0.000000	1,696,402	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0307	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 6/11/2020 7:00 am	
Cost Center Description			Title XVIII	Hospital	PPS	
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		11,934,606		30.00
31.00	03100	INTENSIVE CARE UNIT		3,036,629		31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.241398	1,679,363	405,395	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.020388	388,561	7,922	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.162602	6,664,768	1,083,705	54.00
57.00	05700	CT SCAN	0.019841	3,274,454	64,968	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.050190	360,333	18,085	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.114339	7,565,655	865,049	60.00
65.00	06500	RESPIRATORY THERAPY	0.151147	5,332,813	806,039	65.00
66.00	06600	PHYSICAL THERAPY	0.377805	815,110	307,953	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.779085	276,001	215,028	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.782550	108,087	84,583	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.221707	6,141,534	1,361,621	73.00
74.00	07400	RENAL DIALYSIS	0.429673	333,718	143,390	74.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.235515	2,253,836	530,812	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.755311	142,803	107,861	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		35,337,036	6,002,411	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)		35,337,036		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0307	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 6/11/2020 7:00 am	
Cost Center Description			Title XIX	Hospital	Cost	
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		798,451		30.00
31.00	03100	INTENSIVE CARE UNIT		138,054		31.00
43.00	04300	NURSERY		1,334,414		43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.241398	87,464	21,114	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.020388	150,448	3,067	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161512	194,541	31,421	54.00
57.00	05700	CT SCAN	0.019841	131,440	2,608	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.050190	3,372	169	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.114339	490,057	56,033	60.00
65.00	06500	RESPIRATORY THERAPY	0.151147	184,797	27,932	65.00
66.00	06600	PHYSICAL THERAPY	0.377805	29,282	11,063	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.779085	13,641	10,627	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.782550	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.221707	475,885	105,507	73.00
74.00	07400	RENAL DIALYSIS	0.429673	3,074	1,321	74.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.235515	66,843	15,743	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.755311	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,830,844	286,605	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00		Net charges (line 200 minus line 201)		1,830,844		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A
Date/Time Prepared:
6/11/2020 7:00 am

		Title XVIII	Hospital	PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			6,692,610	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			2,187,123	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)			208,636	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			92,339	2.04
3.00	Managed Care Simulated Payments			3,719,484	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			91.13	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)			2.67	30.00
31.00	Percentage of Medicaid patient days (see instructions)			23.80	31.00
32.00	Sum of lines 30 and 31			26.47	32.00
33.00	Allowable disproportionate share percentage (see instructions)			11.05	33.00
34.00	Disproportionate share adjustment (see instructions)			245,302	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0307	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 6/11/2020 7:00 am
		Title XVIII	Hospital	PPS
			Prior to 10/1	On/After 10/1
			1.00	2.00
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		8,272,872,447	8,350,599,096
35.01	Factor 3 (see instructions)		0.000127690	0.000118393
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		1,056,363	988,652
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		790,101	248,513
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,038,614	
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)		10,464,624	
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)		10,464,624	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		880,921	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)		11,345,545	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		11,345,545	61.00
62.00	Deductibles billed to program beneficiaries		1,183,520	62.00
63.00	Coinurance billed to program beneficiaries		10,230	63.00
64.00	Allowable bad debts (see instructions)		275,116	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		178,825	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		176,538	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		10,330,620	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)		117,230	70.93
70.94	HRR adjustment amount (see instructions)		-40,655	70.94
70.95	Recovery of accelerated depreciation		0	70.95

6/11/2020 7:00 am

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A
Date/Time Prepared:
6/11/2020 7:00 am

		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			28,206	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			10,378,989	71.00
71.01	Sequestration adjustment (see instructions)			207,580	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
72.00	Interim payments			8,971,871	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)			1,199,538	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			642,698	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	0	100.00
HVB Adjustment for HSP Bonus Payment					
101.00	HVB adjustment factor (see instructions)	0.0000000000	0.0000000000		101.00
102.00	HVB adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000		103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
6/11/2020 7:00 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	6,692,610	0	6,692,610		6,692,610
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,187,123	0		2,187,123	2,187,123
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	208,636	0	208,636		208,636
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	92,339	0		92,339	92,339
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	3,719,484	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	0.1105	0.1105	0.1105	0.1105	
11.00	Disproportionate share adjustment (see instructions)	34.00	245,302	0	184,883	60,419	245,302
11.01	Uncompensated care payments	36.00	1,038,614	0	790,101	248,513	1,038,614
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	10,464,624	0	7,876,230	2,588,394	10,464,624
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	10,464,624	0	7,876,230	2,588,394	10,464,624
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	880,921	0	662,652	218,269	880,921

6/11/2020 7:00 am

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
6/11/2020 7:00 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
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	8,538,882	2,806,663	11,345,545
		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	714,194	0	540,744	173,450	714,194
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	166,727	0	121,908	44,819	166,727
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	880,921	0	662,652	218,269	880,921
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.000000	0.000000	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
6/11/2020 7:00 am

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	6,692,610	6,692,610		6,692,610	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,187,123		2,187,123	2,187,123	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	208,636	208,636		208,636	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	92,339		92,339	92,339	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	3,719,484	2,663,607	1,055,877	3,719,484	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	0.1105	0.1105	0.1105		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	245,302	184,883	60,419	245,302	11.00
11.01	Uncompensated care payments	36.00	1,038,614	790,101	248,513	1,038,614	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	10,464,624	7,876,230	2,588,394	10,464,624	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	10,464,624	7,876,230	2,588,394	10,464,624	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	880,921	662,652	218,269	880,921	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			8,538,882	2,806,663	11,345,545	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
6/11/2020 7:00 am

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	714,194	540,744	173,450	714,194	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	166,727	121,908	44,819	166,727	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	880,921	662,652	218,269	880,921	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	117,230	94,734	22,496	117,230	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	-40,655	-32,125	-8,530	-40,655	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	28,206	28,206	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0307	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 6/11/2020 7:00 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		8,646	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		6,075,868	2.00
3.00	OPPS payments		4,589,909	3.00
4.00	Outlier payment (see instructions)		1,223	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		8,646	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		51,201	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)		51,201	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)		51,201	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		42,555	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		8,646	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)		4,591,132	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)		936,965	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)		3,662,813	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)		3,662,813	30.00
31.00	Primary payer payments		1,772	31.00
32.00	Subtotal (line 30 minus line 31)		3,661,041	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)		155,661	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		101,180	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		113,511	36.00
37.00	Subtotal (see instructions)		3,762,221	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-41	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)		3,762,262	40.00
40.01	Sequestration adjustment (see instructions)		75,245	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		3,584,432	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		102,585	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: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part I
Date/Time Prepared:
6/11/2020 7:00 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		8,971,871		3,584,432	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		8,971,871		3,584,432	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		1,199,538		102,585	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		10,171,409		3,687,017	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: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part II
Date/Time Prepared:
6/11/2020 7:00 am

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

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

Provider CCN: 14-0307

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

Worksheet G

Date/Time Prepared:
6/11/2020 7:00 am

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	2,242	0	0	0	1.00
2.00 Temporary investments	0	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	35,925,805	0	0	0	4.00
5.00 Other receivable	1,326,825	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-25,485,663	0	0	0	6.00
7.00 Inventory	1,209,529	0	0	0	7.00
8.00 Prepaid expenses	290,262	0	0	0	8.00
9.00 Other current assets	410,000	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)	13,679,000	0	0	0	11.00
FIXED ASSETS					
12.00 Land	9,200,000	0	0	0	12.00
13.00 Land improvements	7,170,323	0	0	0	13.00
14.00 Accumulated depreciation	-2,222,235	0	0	0	14.00
15.00 Buildings	113,573,684	0	0	0	15.00
16.00 Accumulated depreciation	-24,622,394	0	0	0	16.00
17.00 Leasehold improvements	0	0	0	0	17.00
18.00 Accumulated depreciation	0	0	0	0	18.00
19.00 Fixed equipment	0	0	0	0	19.00
20.00 Accumulated depreciation	0	0	0	0	20.00
21.00 Automobiles and trucks	0	0	0	0	21.00
22.00 Accumulated depreciation	0	0	0	0	22.00
23.00 Major movable equipment	31,354,529	0	0	0	23.00
24.00 Accumulated depreciation	-18,195,260	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	22,191,172	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	138,449,819	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	0	0	0	0	31.00
32.00 Deposits on leases	242,554	0	0	0	32.00
33.00 Due from owners/officers	0	0	0	0	33.00
34.00 Other assets	1,602,602	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	1,845,156	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	153,973,975	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	843,153	0	0	0	37.00
38.00 Salaries, wages, and fees payable	3,638,913	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	0	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	0	0	0	0	43.00
44.00 Other current liabilities	7,968,760	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	12,450,826	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	0	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	880,369	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	880,369	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	13,331,195	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	140,642,780				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)	140,642,780	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	153,973,975	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0307

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

Worksheet G-1

Date/Time Prepared:
6/11/2020 7:00 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-66,084,234		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-15,435,071				2.00
3.00	Total (sum of line 1 and line 2)		-81,519,305		0		3.00
4.00	TRANSFER FROM BJC	222,078,060		0		0	4.00
5.00	RELEASE OF RESRTRICTED ASSETS	84,025		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)		222,162,085		0		10.00
11.00	Subtotal (line 3 plus line 10)		140,642,780		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		140,642,780		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	TRANSFER FROM BJC		0				4.00
5.00	RELEASE OF RESRTRICTED ASSETS		0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0307

Period:
From 01/01/2019
To 12/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
6/11/2020 7:00 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	63,965,985		63,965,985	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	63,965,985		63,965,985	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	6,508,260		6,508,260	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)	6,508,260		6,508,260	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	70,474,245		70,474,245	17.00
18.00	Ancillary services	67,380,872	48,917,788	116,298,660	18.00
19.00	Outpatient services	0	156,105,325	156,105,325	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	137,855,117	205,023,113	342,878,230	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		89,146,204		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		89,146,204		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0307

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

Worksheet G-3

Date/Time Prepared:
6/11/2020 7:00 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	342,878,230	1.00
2.00	Less contractual allowances and discounts on patients' accounts	266,057,973	2.00
3.00	Net patient revenues (line 1 minus line 2)	76,820,257	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	89,146,204	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-12,325,947	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	35,937	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	357,115	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	1,780	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	21,008	20.00
21.00	Rental of vending machines	14,178	21.00
22.00	Rental of hospital space	1,097,570	22.00
23.00	Governmental appropriations	0	23.00
24.00	MEDICAID MEANINGFUL USE	0	24.00
24.01	MEDICARE MEANINGFUL USE	0	24.01
24.02	BJC SHARED SAVINGS	-53,102	24.02
24.03	BJC OTHER OPERATING REVENUE	139,296	24.03
24.04	MISC OTHER OPERATING REVENUE	-76,575	24.04
24.05	ROUNDING	0	24.05
25.00	Total other income (sum of lines 6-24)	1,537,207	25.00
26.00	Total (line 5 plus line 25)	-10,788,740	26.00
27.00	PHYSICIAN PRACTICE OPERATIONS-BJCMG	4,542,879	27.00
27.01	PHYSICIAN OFFICE BUILDING	0	27.01
27.02	BJC ACO OPERATIONS	103,449	27.02
27.03	ROUNDING	3	27.03
28.00	Total other expenses (sum of line 27 and subscripts)	4,646,331	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-15,435,071	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0307	Period: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III Date/Time Prepared: 6/11/2020 7:00 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		714,194	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		166,727	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)		38.58	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		880,921	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